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Illinois Medical Journal

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JANUARY, 1969

VOLUME 135, NO. 1

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CHICAGO MEDICAL SCHOOL





In childhood diarrheas

- careful supervision
- electrolyte replacement
- specific anti-infective therapy and

LOMOTIL®

tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

X 70 - 3023

Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

LOMOTIL in conjunction with specifically indicated medical management may be life saving in children with severe diarrhea associated with such conditions as acute infections, gastroenteritis, drug therapy and food poisoning.

Lomotil lowers the excessive intestinal propulsion characteristic of diarrhea. This reduction of precipitate intestinal flow allows a normal or more nearly normal reabsorption of fluid and electrolytes and counteracts the dehydration so hazardous to children.

This specific, well localized pharmacologic activity controls both acute infectious diarrheas and long-term functional and organic diarrhea with unsurpassed promptness, convenience and efficiency.

PROMPT • EFFECTIVE • CONVENIENT

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children: Total Daily Dosage

3-6 mo.	1/2 tsp.* t.i.d. (3 mg.)	↓↓↓
6-12 mo.	1/2 tsp. q.i.d. (4 mg.)	↓↓↓↓
1-2 yr.	1/2 tsp. 5 times daily (5 mg.)	↓↓↓↓↓
2-5 yr.	1 tsp. t.i.d. (6 mg.)	↓↓↓↓
5-8 yr.	1 tsp. q.i.d. (8 mg.)	↓↓↓↓↓
8-12 yr.	1 tsp. 5 times daily (10 mg.)	↓↓↓↓↓
Adults:	2 tsp. 5 times daily (20 mg.)	↓↓↓↓↓↓↓↓
	or 2 tablets q.i.d.	○○○○○○○○

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

SEARLE

Research in the
Service of Medicine

BLUE SHIELD REPORT



FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 222 NORTH DEARBORN AVENUE • CHICAGO, ILLINOIS 60601

Vol. 3, No. 1

January, 1969

AMA Resolutions

House of Delegates, Miami Beach—1968.

I. "Whereas, There is presently renewed and steadily increasing interest on the part of medical and consumer groups for the provision of broad coverage and economical medical care.

Whereas, There is interest in voluntary health insurance for medical services as being one of the best possible means of furthering this objective; therefore be it

Resolved, That the House of Delegates of the American Medical Association reaffirm its belief that the concept of voluntary health insurance is the most acceptable means of financing health care when applied in keeping with the principles of the American Medical Association."

II. "Usual, Customary, and Reasonable."

"Whereas, There is a rapidly increasing number of programs for financing health services based upon the *usual*, *customary*, and *reasonable* concept for payment of physicians' services; and

Whereas, It is in the best interest of the public and physicians of the country that a national definition of the terms, *usual*, *customary*, and *reasonable* be formulated by the American Medical Association; therefore be it

Resolved, That the American Medical Association adopt the following definitions and distribute them to all state medical associations for their individual consideration and guidance:

Usual is defined as that fee which is consistently charged for a given service by an individual physician in his personal practice (i.e., *his own usual fee*);

Customary is defined as that range of usual fees charged by physicians of similar training and experience for the same service within a given specific limited geographic or socio-economic area;

Reasonable is defined as a fee which meets the above two criteria, *or*, in the opinion of the responsible local medical association's review committee, is justifiable in the special circumstances of the particular case in question.

And be it further resolved that, whenever these terms are used in contracts or laws, that specific definitions be used."

FEDERAL EMPLOYEES PLAN GOES USUAL AND CUSTOMARY

Federal employees in Illinois holding "high-option" Blue Shield contracts now enjoy the protection of Usual and Customary payments for physicians' services.

A broad scope of services which have been covered on an indemnity basis heretofore will now be paid under the Usual and Customary formula.

The range of covered services includes: Surgery wherever performed; In-hospital Medical care, including psychiatric and intensive care; Obstetrics; diagnostic X-ray and Laboratory tests; Radiation Therapy; Anesthesia; and accident care.

This new program which became effective for over 160,000 members of the Plan on January 1st of this year, is the most significant upgrading of Blue Shield benefits for Illinois members of this group since the program began in 1960.

Physician-Patient Ratio Improves

The ratio of physicians to patients in the United States at the end of 1967 was 151.5 physicians per 100,000 population. There were about 308,630 physicians with M.D. degrees and the population came to 230,708,000, according to an American Medical Association survey. This ratio compares favorably with statistics from a 1963 survey which showed 276,475 physicians with M.D. degrees and a population of 194,169,000—a ratio of 142.4 physicians per 100,000 population.

Our government contracts division

reported that Federal Health Insurance benefits under Title XVIII, Part B of P.L. 89-97 were paid during October for over 46,000 cases in the counties of Cook, DuPage, Kane, Lake, and Will for an amount exceeding \$3,700,000. For the year 1968 through October, payments have been made on 619,227 cases for more than \$39,000,000.

The number of cases processed in October under Part A (all Illinois) exceeded 61,000 with payments to providers amounting to \$22,402,797. For the year 1968 through October, over 672,000 cases have been processed and payments to providers totaled \$195,720,919.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Q What specific information is required on my bills in order to permit Medicare payments to my patients?

A It is necessary to include specific dates of each service, the services rendered, charges for each service, and diagnosis.

Q Will I be notified when payment has been made to my patient on an itemized bill?

A You will not be notified. The matter of payment is between you and your patient. If you accept assignment, the patient will be notified when payment is made to you so that he will know what balance is due.

Q Are influenza inoculations for beneficiaries a covered expense?

A No. Immunizations are specifically excluded by the law.

Q Can charges for prescription drugs be applied towards the \$50 deductible?

A No. Only services covered by Medicare can be applied towards the deductible.

Q Must I have the patient or an authorized representative sign the "Request for Payment" form when I accept assignment?

A Yes. There are a few exceptions, if the patient is unable to sign or cannot be located or is deceased and had no relatives. Attach a note explaining why there is no signature and the claim will be considered for payment.

Q How do I obtain Medicare payment when my patient has died and there is no next of kin or other responsible person to sign the SSA form 1490?

A If you accept assignment, attach a letter to the SSA form 1490 explaining that you were unable to obtain a necessary signature. If you do not wish to take an assignment, the only alternative is to bill the estate of the deceased.

Q If I have accepted assignment on a patient who is deceased, must I accept the Medicare payment as payment in full?

A No. The estate of the patient may be billed for any of the unmet \$50 deductible as well as the 20% not payable by Medicare. However, in this case, as well as any other assignment, any charges over the reasonable charge determination may **not** legally be billed to the patient or his estate.

NOTICE

To help speed Medicare payments, physicians in the counties of Cook, DuPage, Kane, Lake and Will may obtain a supply of SSA 1490 Request for Payment forms with their name imprinted on them by writing to Government Contracts Division, Blue Cross-Blue Shield, 222 North Dearborn Street, Chicago, Illinois 60601.

Simple Errors on Forms Cause Payment Delays

Pennsylvania Blue Shield and the Social Security Administration recently completed a survey of 1,000 Medicare Request for Payment forms 1490 to determine the causes for delays in claim processing. The results were very interesting.

The most common error for delays in processing a claim was **INCORRECT CLAIM NUMBERS** (64% of the delayed claims). Omission of the *letter suffix* was the most common error. 510 of the forms with incorrect claim numbers were marked for assignment, while only 130 were non-assigned claims. Since most assigned claims are prepared in the doctor's office, this was most surprising.

34% of the claims had *address deficiencies, errors or omissions*.

The other 2% of the claims in the survey were classified as miscellaneous errors.

Moral: Correct completion of routine information identifying the beneficiary in Part I of the Medicare Request for Payment form will speed processing and reduce time-consuming delays in paying claims.

The survey team suggested the following steps be followed to avoid errors and delays:

1. Take the claim number directly from the beneficiary's Medicare health insurance card.
2. Make sure that all digits and letter suffix are included.
3. Use the beneficiary's name as shown on his health insurance card.
4. Ask the beneficiary for his house number, street, city and zip code. Such items are necessary parts of his address.

Physical Exams—Pap Tests

Medicare law makes no provisions for payments for routine physical examinations. SSA defines an examination as routine when they are "performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint or injury."

Whether the excluded procedures are performed by the doctor himself or whether he refers the patient elsewhere to have them performed, the procedures are not covered under Medicare.

Many questions have been raised in regard to Medicare payments for Papanicolaou tests. The SSA Bureau of Health Insurance has drawn up a criteria to determine whether a "Pap smear" is covered. It will be covered if it is performed for one or more of the following reasons:

1. Previous cancer of the cervix, uterus or vagina which has already been tested. The "Pap smear" would be for the purpose of follow up care.
2. Previous abnormal "Pap smears."
3. Irritation or inflammation of the cervix as determined by physical examination.
4. Abnormal vaginal bleeding.
5. Abnormal vaginal discharge.

DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:

Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.

(Warning: May be habit forming)

To reduce hypermotility and frequency.

Homatropine Methylbromide... 0.15 mg.

A safe dose for mild spasmodic to curb cramping and griping.

Pectin... 24. mg.

Demulcent, adsorbent. Helps form stools.

Alcohol 10% by volume.

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's rule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

DIA-QUEL LIQUID



INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976

The president's page



Philip G. Thomsen, M.D.

Our Legislative Program Needs County Groundwork

Last month on this page, I said the group strength of physicians was rooted in the county medical societies.

This month the 76th Illinois General Assembly convenes.

What I said in December, and what happens in Springfield, have a real bearing on each other.

Your ISMS House of Delegates has called for good, solid legislation to advance health, safety and medical education in Illinois. But we need staunch backing at the county level.

Sheer highmindedness will not carry our program—our proposals for an Implied Consent Law and Medical Review Board to make driving safer, per-student subsidies to med schools, and permission for hospital emergency-room consolidation. Energy must be expended—at the grassroots as well as in Springfield.

Our ISMS representatives will be conferring constantly with legislators. As spokesmen for an important professional society, they will be influential—up to a point. But you and your wife . . . your county medical society and its auxiliary . . . can exert a special influence, because you can talk as constituents to your Assembly members.

While the November election results promise a favorable climate for advances in health and safety, we must be on our guard against possibly dangerous bills. ISMS and the county medical societies

must be prepared to join arms in any contingency.

Our legislative staff studies each bill as it is introduced. We will transmit our interpretations to the county societies in an effort to get their views and plan joint action.

To work effectively on legislative problems, the county societies must have the proper organizational mechanism.

About half of them now have committees on legislation. Public affairs are handled in some cases by these committees, in others by a separate committee.

We at ISMS recommend that one committee handle both functions. From a practical standpoint, the functions are inseparable. Public affairs are simply an extension of the legislative process.

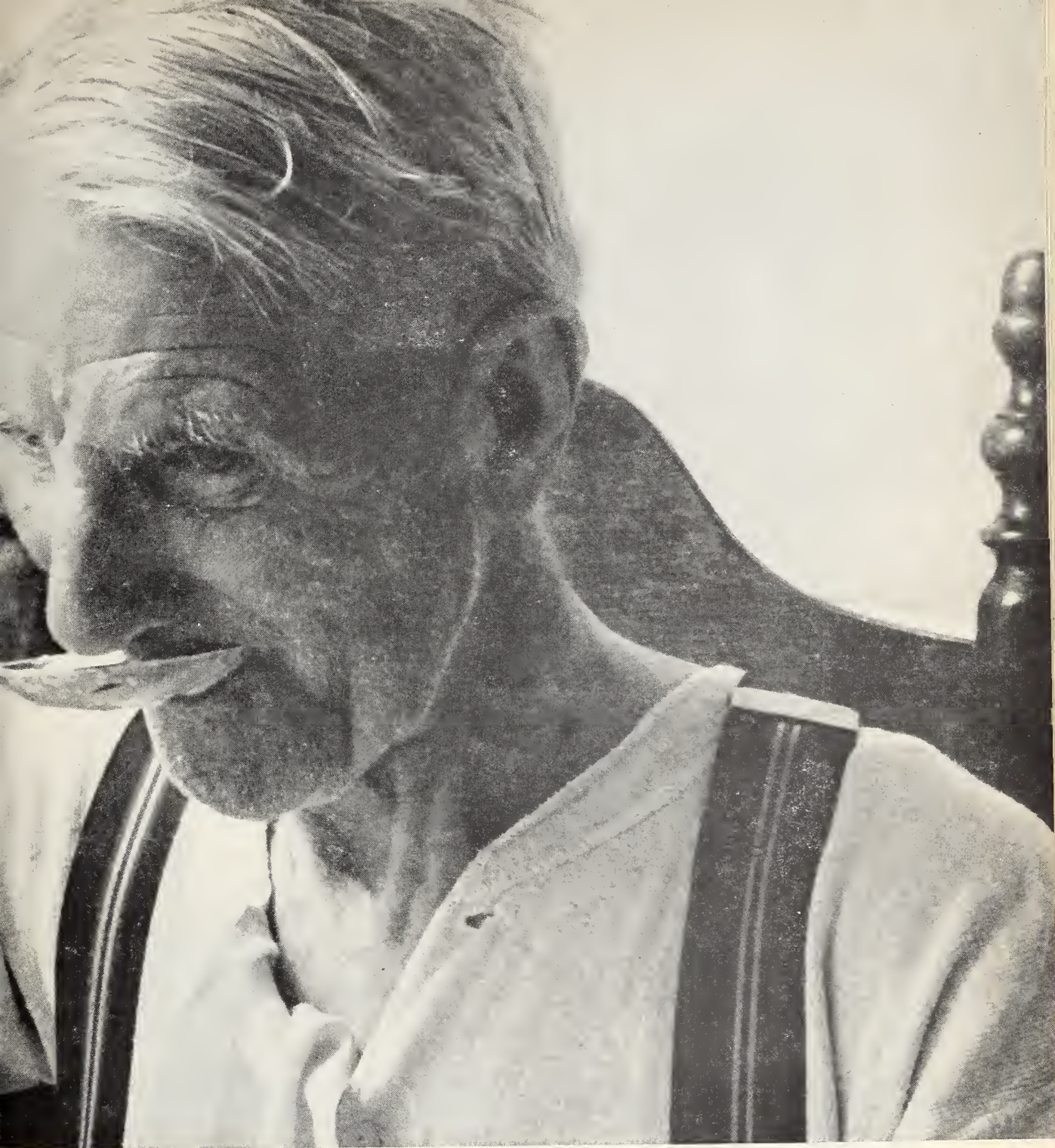
Terms of the committee members should be staggered, to assure *continuity of knowledge and knowhow*.

If your county society lacks the proper legislative mechanism, take steps to mold it NOW.

ISMS and your county society need each other's strength during the 76th General Assembly . . . and in the legislative elections two years hence.

We need each other's strength in all the ways that affect the health and safety of 10,000,000 Illinoisans.

Philip G. Thomsen M.D.



rently. Like other thiazide diuretics, polythiazide may cause a rise in serum uric acid levels, disturb glucose tolerance even in previously normal patients or decrease PBI levels without signs of thyroid disturbance. Thiazide drugs may augment the paralyzing actions of tubocurarine, and may decrease the arterial responsiveness to norepinephrine. The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Reserpine—Avoid or use cautiously in patients with a history of peptic ulcer or ulcerative colitis, patients with impaired renal function and in those receiving digitalis or quinidine. Extreme caution is needed in patients with a history of mental depression. If depressive symptoms, confusion or parkinsonism develop, discontinue use. Discontinue two weeks before elective surgery to avoid an unexpected degree of bradycardia and hypotension. For emergency surgery, vagal

blocking agents may be used to prevent or reverse hypotension and/or bradycardia. May cause increased appetite and weight gain.

ADVERSE REACTIONS: Polythiazide—With electrolyte imbalance: nausea, vertigo, weakness, paresthesias and fatigue. Most of these can be overcome by reducing the dose or taking measures to improve electrolyte imbalance. Maculopapular rash, reversible cholestatic jaundice, leukopenia, purpura (with or without thrombocytopenia), agranulocytosis, aplastic anemia, pancreatitis, photosensitivity, gastrointestinal disturbances, headache, xanthopsia, necrotizing angitis, orthostatic hypotension and dizziness have been reported.

Reserpine—Hypersecretion, nausea and vomiting, anorexia, diarrhea, angina-like symptoms, arrhythmias (particularly when used concurrently with digitalis or quinidine), flushing of the skin, bradycardia, drowsiness, depression, nervousness, paradoxical anxiety,

nightmares, parkinsonian syndrome, and C.N.S. sensitization manifested by deafness, glaucoma, uveitis, and optic atrophy have occurred. Nasal congestion is a frequent complaint, and pruritus, rash, dryness of mouth, dizziness, headache, purpura, impotence or decreased libido, and miosis have been reported with use of this drug. These reactions are usually reversible and disappear when the drug is discontinued.

SUPPLY: Scored tablets (2 mg. polythiazide—0.25 mg. reserpine), blue. Bottles of 100 and 1,000.

More detailed professional information available on request.

Pfizer

LABORATORIES DIVISION

New York, N. Y. 10017

ON THE COVER

After nearly sixty years since its founding, the Chicago Medical School entered a new era of medical education when it announced in 1966 the establishment of a University of Health Sciences—one of the first schools for physicians and related health professionals. Also, to help meet the shortage of qualified teachers in the basic medical sciences, the School of Graduate and Postdoctoral Studies offers M.S. and Ph.D. research degree programs in the fields of anatomy, biochemistry, microbiology, pathology, pharmacology and physiology.

This past September, 82 first year medical students—the largest class in the history of the school—began study in the modern 11-story building at 2020 W. Ogden Ave. The move to consolidate teaching and research facilities in one location was another step toward developing a closer academic relationship between students, faculty and medical researchers.

During the summer months revision of the 11-story structure originally built by CMS in 1960 as a research facility was completed. Dr. A. Nichols Taylor, provost, pointed out that the move will not provide a greatly improved teaching environment, but it will make possible an increase in the number of students that can be accommodated.

"Space and facilities are now available to continue development of the School of Related Health Sciences and the School of Graduate and Postdoctoral Studies," he said, "which will provide interlocking educational programs for a variety of health workers at the professional and technical levels, and for advanced programs at the Masters and Doctoral levels required for teachers and researchers in medicine and other health sciences."

In 1912 a group of young Chicago physicians and civic-minded citizens founded the Chicago Medical School. Together they raised sufficient funds to obtain a charter to operate a medical school and hospital under the name of The Chicago Hospital College of Medicine. Their dream was to build a combined medical school and hospital where employed men and women could study medicine at night—a practice not uncommon among the nearly 40 medical schools existing in Illinois at that time.

In 1915, the group purchased a building at 3832 South Rhodes Avenue, and the name was changed to the Chicago Medical School. When the Jenner Medical College, staffed by many of Chicago's finest medical teachers and practitioners, closed its doors in 1917 after 24 years, many of the faculty and students transferred to CMS.

The school moved in 1930 to 710 South Lincoln Avenue (now Walcott) across from Cook County Hospital and within what is now a vast 383-acre medical center on Chicago's west side, a medical complex unequalled anywhere in the world. The building was formerly the Francis Willard Temperance Hospital and there is an apocryphal story that alcohol was not permitted in any form and acetane was used instead for surgery.

The faculty at CMS is presently staffed by widely-recognized teachers, scholars and investigators, and of the 140 full-time teachers, assisted by 560 part-time and voluntary members, many are engaged in significant research work.

Another important element of a medical school is its curriculum and CMS has recently developed a broader system of clinical teaching including: introducing clinical medicine at the end of the second year of study; a full year of clinical study in the third year; an elective quarter in the fourth year; and a total restructuring of courses to cut across interdisciplinary lines.

Mt. Sinai Hospital Medical Center is the primary teaching hospital for the school, where all clinical departments are based. In addition, the third and fourth year students train at Cook County Hospital, Schwab Rehabilitation Hospital, Illinois State Psychiatric Institute and other medical facilities within the city.

Since its establishment, the school has graduated over 4000 physicians, and alumni are practicing in 42 states and many foreign countries.

MEDICINE IN THE SEVENTIES

ISMS Annual Convention

May 19-21, 1969

Sherman House, Chicago

Fatal Hemorrhage Following Tracheostomy

By JULIUS CONN, Jr., M.D., GEORGE A. TOLIS, M.D.,
AND THOMAS W. SHIELDS, M.D./CHICAGO

Massive hemorrhage is the most serious sequela of a tracheostomy. Most often it terminates fatally and is seen in approximately one per cent of the patients who undergo the procedure. The bleeding results from fistulization between the trachea and a major vessel in the neck or mediastinum. Proper placement of the stoma, proper fitting of the tracheostomy tube and avoidance of infection will reduce the incidence. Once massive hemorrhage occurs, control by balloon tamponade of the fistulous opening and direct repair of the arterial defect may be attempted but is frequently doomed to failure because of infection in the operative field.



Julius Conn, Jr., M.D., (left) is currently Associate Professor of Surgery, Northwestern University Medical School. He received his B.A. and M.D. from the University of Virginia. Dr. Conn is on the staffs of the V.A. Research and Passavant Memorial Hospitals,

Chicago. Thomas W. Shields, M.D., (not pictured) is Professor of Surgery, Northwestern University Medical School. He is affiliated with the V.A. Research Hospital, Passavant Memorial Hospital, as well as the Chicago Municipal Tuberculosis Sanitarium. Dr. Shields has also served as Associate Editor of *Surgery, Gynecology & Obstetrics* since 1967. George A. Tolis, M.D., (not pictured) is currently an instructor at Northwestern University Medical School. He received his M.D. from the University of Athens, Greece.

Tracheostomy is a frequently employed life-saving procedure. Though initially it was utilized to bypass laryngeal obstruction, the procedure now finds its most frequent use in patients who cannot maintain a patent airway, in patients who are unable effectively to clear secretions from the tracheobronchial tree and in those patients who require prolonged assisted or controlled ventilation.

Unfortunately, tracheostomy is neither a simple operative procedure nor is it devoid of early or late serious, and at times, life-threatening complications. Massive hemorrhage is by and large the most serious operative and postoperative sequela.^{2,4,11} Tracheal stenosis may also occur as does infection and the many other complications recorded in the literature.^{7,15}

Hemorrhage at the time of the operation may be from failure of adequate hemostasis or inadvertent injury to the great vessels of the neck. Both of these sources may be avoided by proper care and technic during the operative procedure. Delayed hemorrhage may occur from ulceration of the tracheal mucosa or from fistulization and rupture of a major artery into the trachea. Though fistulization to the common carotid arteries, the thyroid arteries, or an aortic aneurysm may occur, the innominate artery is the most common vessel involved.

Recently we encountered a patient who developed a fatal massive hemorrhage 39 days following a tracheostomy. At autopsy, fistulization to the innominate artery was noted as well as stenosis of the trachea inferior to the site of fistulization.

Case Report

The patient, a 20-year-old white man, was admitted to Passavant Memorial Hospital, Chicago, July 18, 1967, in acute renal failure, following a period of progressive edema, weakness, shortness of breath, of several months' duration.

Peritoneal dialysis was initiated shortly after admission and numerous diagnostic procedures were carried out to determine the cause of the renal failure. On the 10th hospital day, operative exploration and right kidney biopsy were performed. During the procedure cardiac arrest occurred. Though cardiac resuscitation was successful, the patient remained in a semi-comatose state. For several days recurrent episodes of convulsions occurred. A patent air-

Fig. 1. Anterior surface of aortic arch, great vessels and trachea. Catheter placed through tracheostomy stoma and seen lying within the lumen of the aorta.



way was maintained for the first 24 hours by an indwelling endotracheal tube and then a standard tracheostomy was performed, and the endotracheal tube removed. A 13 mm. plastic cuffed tube was utilized to maintain the airway and assisted ventilation was maintained by a mechanical respirator. Three days post-tracheostomy the patient became febrile and copious amounts of purulent secretions were removed from the tracheobronchial tree via the tracheostomy. Heavy growths of pseudomonas and staphylo aureus coagulase positive were cultured from the secretions. Nafcillin and Polymyxin B were added to the patient's therapeutic regimen.

In 10 days the patient's condition had improved somewhat and he was taken off the assisted ventilation. There was some difficulty maintaining an open airway and for this reason the cuffed tracheostomy tube was replaced by a #4 silver tracheostomy tube.

The patient's subsequent course was marked by intraperitoneal complications of the peritoneal dialysis, massive lower gastrointestinal bleeding, and bronchopneumonia. All were treated by conservative medical management. On 9-6-1967 respiratory stridor was noted, the trachea was aspirated and appeared patent. Suddenly massive bleeding occurred from the tracheostomy and the patient expired before effective resuscitative measures could be carried out.

At autopsy the pulmonary tree was found filled with blood. Atelectasis of the right lower lobe, bilateral pleural effusion, mild pulmonary edema, moderate cardiac enlargement, swollen and pale kidneys, pelvic abscess and enterocolitis also were demonstrated.

The tracheostomy stoma was located at the second tracheal ring. Severe stenosis of the trachea, several centimeters below the stoma was present. Just above the stenotic area, two distinct punctiform ulcerations were identified on the anterior and posterior tracheal wall. The anterior ulceration led directly into the innominate artery (Figs. 1 and 2). The posterior ulcer involved the entire thickness of the tracheal wall but no fistula into the esophagus could be demonstrated.

Massive hemorrhage from a tracheostomy is a most dramatic and distressing

event.^{1,2,3,12} The incidence of this complication, in a large series of tracheostomies, is approximately one per cent.^{5,6,8,9,13,14} The time of occurrence varies from a few days to several months.

Inadequate hemostasis is the causative factor for the bleeding occurring shortly after tracheostomy. Delayed hemorrhage results from ulceration of the trachea with erosion into a great vessel in the neck; the most common being the innominate artery. In most of the recorded experiences, this most commonly follows a tracheostomy placed low in the trachea, below the third or fourth tracheal ring. Direct pressure erosion of the trachea and subsequently the innominate artery by the inferior concave border of the tube, takes place at the level of the stoma.¹² Local infection must also be implicated in the causation of the complication. Only infrequently does massive hemorrhage occur with a stoma placed high in the trachea. In the reported patient the stoma was at the level of the second ring, well away from the innominate artery and the fistulization occurred several centimeters below the stoma; most likely at the site of the lower end of the tube. This possible mode of injury has been previously noted by Davis and Southwick.²

The treatment of this complication is not frequently possible but recently, temporary control of the bleeding by balloon tamponade, then direct operative correction has been suggested and attempted by several authors as the only life-saving procedure.^{1,5,12} Only recently has the first successful outcome been reported.¹⁰ Unfortunately, in most instances arterial reconstruction by any means in an already infected field has resulted in almost universal failure.

The best treatment is to avoid the catastrophic hemorrhage. The tracheostomy should be done in the operating room under aseptic conditions, with good light and assistance, in order to avoid injury to the trachea and the surrounding neck vessels. The tracheostomy stoma must be at the level of the 2nd or 3rd ring and away from the great vessels. Pulsations of the tube usually indicate low tracheostomy.^{2,12} The stoma then should be replaced at a higher level. The tube must be of the proper size and should not impinge against the wall of the trachea, since pressure by the tip of a

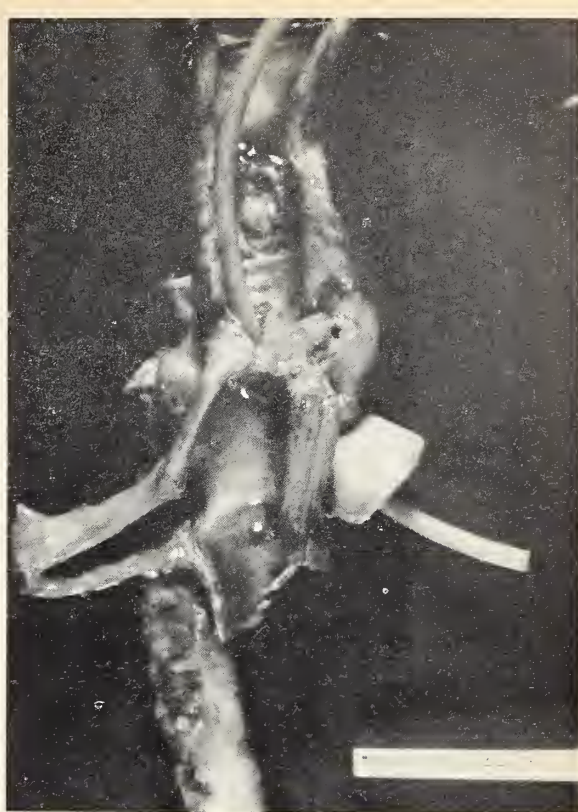


Fig. 2. Posterior view with back wall of trachea removed showing tracheal stoma well above site of fistulization into innominate artery. Area of marked stenosis of trachea just below fistula site.

long tube against the anterior wall of the trachea will result in ulceration and possible fistula formation. When a cuffed tracheostomy tube is used the pressure utilized to inflate the balloon should be the minimal necessary to prevent air leaks when patient is on either controlled or assisted respiration. In a long standing tracheostomy, frequent inspections of the trachea will detect early lesions such as ulceration or stenosis. Last, but not least, aseptic technique by the staff dealing with toilet of the bronchial tree, is essential to eliminate infection.

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(Continued on page 102)

Evaluation of the Coronary Suspect

By CHARLES E. THOMPSON, M.D./CHICAGO

For the past fifteen years many physicians have been studying coronary artery problems from diverse points of view and, as a result, literally thousands of manuscripts have been presented in cardiac literature. The trend toward studying coronary risk factors has been an outstanding advance in the field of cardiac investigation. Such studies have established the existence of the "coronary prone" or "coronary suspect" individual and have presented this person to each physician an opportunity to practice preventive medicine against the number one killer of civilized people.¹

The following study was performed on a population of 8,500 "well people," namely executives, examined periodically over a period of twelve years. The purpose of the examination was to look at the total individual; it was accomplished through comprehensive examination by certified internists. Included in this study were the following factors.

1. Evaluation of "coronary proneness" of each individual, as well as total diagnostic evaluation and disease incidence.
2. Study of 120 deaths known to occur in this group, including the evaluation of the risk factors of 44 coronary deaths.
3. Study of 905 consecutive examinees for the coronary risk factors done during the summer and fall months of 1966.

The results of the first factors have been reported elsewhere.² Studies have verified

Charles E. Thompson, M.D., is associate professor at the Northwestern University School of Medicine. This paper was originally presented at the 1968 Annual Convention of the Illinois State Medical Society.

that, in addition to the major recognized factors, a probable statistical relationship of elevated serum uric acid level and low thyroid states exists.³ A final evaluation will be made shortly on both of these factors as based on the study of 905 consecutive examinees.

All other considerations aside, death is the final evaluation of coronary disease. Of the 8,500 examinees studied, 44 deaths occurred caused by acute myocardial infarction. The relationship to Coronary Risk Factors, based on this group of 44 men, are as follows:

Table I

Average age of death	55.4 yrs.
Elevation of serum cholesterol level (over 300 mgs%)	40
Elevation of blood pressure (greater than 140/90)	23
Obesity (Physician's evaluation + weight + height)	24
Evaluation of fasting blood sugar (over 110 mgs%)	22
Abnormal electrocardiographic findings	25

Table II

Relationship of combinations of factors to total coronary deaths		
Those having		
1 factor	6	
2 factors	11	
3 factors	12	
4 factors	13	
5 factors	2	
Average time span between first examination and death	2 yrs. 3 mos.	
Those having other factors not generally a factor in myocardial infarction death	4	
Old RHD	2	
Moenckeberg Sclerosis	1	
Ploicythemia	1	

Table III
THOMPSON TRIOSORB STUDY
PERCENTAGE OF 905 PATIENTS WITH REGARD TO NORMAL
PHYSICAL AND LABORATORY MEASUREMENTS

Variable	Values		Percent of Patients	
	Not To Exceed		Normal	Abnormal
Weight Normality	Medical	Eval.	93.9	6.1
Systolic BP (mm Hg)	139		73.0	27.0
Diastolic BP (mm Hg)	89		76.3	23.7
Glucose (mm/100 ml)	100		52.9	47.1
Cholesterol (mm/100 ml)	270		69.9	30.1
SED Rate (mm in 1 hr)	12		62.3	37.7
Uric Acid (mg/100 ml)	7.5		77.0	23.0
T3 (%): (Lower Limit)	38.0	(50.0)	71.6	11.1 (17.3)

It becomes apparent that most fatal cases of coronary disease have more than one factor in operation to produce the chain of events leading to the fatal heart attack. Certainly, elevated serum cholesterol is the most frequent offender. The other factors occur in various combinations usually associated with serum cholesterol elevations.

Table III illustrates the abnormalities as seen in the consecutive series study of 905 examinees. This shows the percentage of normal and abnormal findings of examinees based on the established normal physical and laboratory measurements. It is readily seen as one studies the so-called healthy man, laboratory and physical abnormalities appear; such observations have been repeatedly made. In the above study, standards for the fasting blood sugar, 100 mgs%, are not those accepted in other mass studies; 110 mgs% is a more realistic figure.

On the other hand, the standard of 270 mgs% for cholesterol has given this group a 10 mgs% bulge over the accepted 260 mgs%. Long clinical experience by repeated study of periodic sampling and split sampling with other laboratories has shown that 260 mgs% is an accurate figure. Further samples seem to come up with the consistent 30% elevated blood serum cholesterol.

When a computer is used to analyze the statistical description and data by standard deviations, low, high and mean, a more realistic evaluation is evident. (Table IV) However, no matter which way the figures come out, it is still apparent that cholesterol is the number one offender. Other factors, as evidenced in this study are: blood pressure, disturbance of the sugar metabolism in varying degrees, and weight.

When one looks at the death patterns, and again at the examinees 10 years prior to the ultimate result (45.9 years to 55.4 years), there is a similarity of causative agents. This evidence then, leads to the conclusion that there is a true relationship that is well enough established to produce a "coronary suspect."

To discuss this matter a bit further, these factors are known and can easily be recognized. It is, then, the duty of physicians to study their patients in this regard. Ask yourself if each patient is a "coronary suspect." Examinations that are carefully done and that use the appropriate laboratory facilities make recognition easy. The hope that we have at the present time of reducing the mortality, the morbidity of the acute attack, rests with the recognition and proper treatment with currently available drugs, diet, and exercise to control or to use a surveillance technique

Table IV
THOMPSON TRIOSORB STUDY
STATISTICAL DESCRIPTION OF PATIENT CHARACTERISTICS
AND LABORATORY MEASUREMENTS FOR 905 PATIENTS

Variable	Low	High	Mean	Std. Dev.
Age (yrs.)	13	80	45.9	9.6
Sex	Males: 832 (91.9%)		Females: 73 (8.1 %)	
Height (in.)	56	79	69.4	3.1
Weight (lbs.)	104	284	176.3	25.2
Systolic BP (mm Hg)	86	200	131.2	15.8
Diastolic BP (mm Hg)	54	124	82.9	9.0
Glucose (mg/100 ml)	72	294	100.2	14.4
Cholesterol (mg/100 ml)	114	486	254.8	39.4
SED Rate (mm in 1 hr.)	10	49	12.0	8.0
Uric Acid (mg/100 ml)	2.3	12	6.7	1.2
T3 (%)	20.0	49	33.4	3.8

on the factors known to produce myocardial infarction. It is not enough to use such techniques after the patient has had his coronary. This is, of course, a wise and useful treatment. But why not attempt the prevention of the attack?

Reverting back to a comparison of death statistics, in our small study we find the ratio between cancer deaths to coronary deaths to be 1:1. Studies done by the U.S. government, insurance companies, and USPH studies using larger, general population figures show roughly a 3:1 ratio. In an attempt to evaluate these discrepancies, there have been several explanations including one recently done by the Standard

Oil group. This, however, is only part of the answer. Much of the answer is in the knowledge of the patient's understanding of the hazard. Periodic testing and adequate treatment of the factors which make a person, male or female, a coronary suspect are the task of the physician; this is a Herculean task.

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New Protection During Radiation Therapy

University of Chicago doctors have found a better way to protect noncancerous tissue from damage during radiation therapy.

Dr. Robert A. Goepp, Assistant Professor in the Zoller Dental Clinic and in the Department of Pathology, said experiments have shown that direct local application of chemicals can provide more effective protection than injections, the method now used.

His U.S. Public Health Service sponsored research has also demonstrated that directly-applied mercaptoethylamine (MEA) is particularly effective in protecting against the damage to neighboring healthy tissue, which has been a major problem in treating cancer with radiation therapy.

Dr. Goepp has concentrated his research on radiation of the mouth and tongue, because complications of radiation in this highly sensitive area often result in complication in neighboring normal tissues. These complications lead to a greatly increased susceptibility to injury and infection, and the salivary process is destroyed leaving an extremely dry mouth which causes great discomfort for patients.

Basic studies done with mice have demonstrated that radiation given to the mouth area could result in death due to starvation

and dehydration, Dr. Goepp said.

Continuing these studies, he found that radiation destroyed the ability to replace cells in oral tissues. This in turn was caused by a radiation induced halt in the replication of deoxyribonucleic acid (DNA), the basic reproductive molecules in the tissue cells. He verified this hypothesis by injecting radioactively labeled hydrogen into the mice and tracing the activity during DNA synthesis in the tongue.

By using three drugs—MEA, aminothylisotheronium (AET) and para-aminopropiophenimine (PAPP)—injections, Dr. Goepp first demonstrated that more radiation was required to kill the mice. He also found that while the chemicals did not prevent the initial injury, they did protect the recuperative power of the tissue and DNA. Thus, the animals became ill but did not die.

The next step was to apply the chemicals directly to the tongues of mice. Results demonstrated that: 1) the mice were better protected than with injections, 2) initial radiation injury was not as severe, 3) the progress rate of the injury was appreciably slower, and 4) after a time there was a sudden recovery from radiation injury.



IMJ

**SURGICAL
GRAND
ROUNDS**

Celiac Artery Stenosis

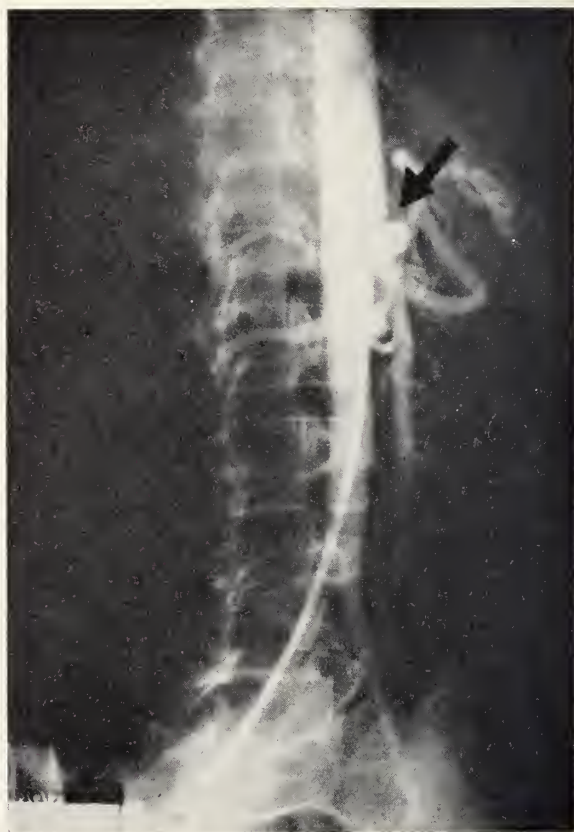
CASE PRESENTATION:

Dr. Edward Kaputska: The patient, a 42 year old white female, was admitted to Passavant Memorial Hospital with a history of weight loss of 50 pounds, intermittent diarrhea, and post cibal abdominal pain of one year's duration. She described the pain as crampy in nature, diffuse over the abdomen, and occurring one-half hour after eating. She stated that she had continued to eat well but lost weight. She was hospitalized approximately six months ago at another hospital for study of intestinal absorption. At that time the investigation was negative, and a diagnosis of spastic colon was made. She has been taking various antispasmodics. She was admitted here in March of this year with similar complaints. Physical examination at the time of admission was negative. Abdominal tenderness was absent. The patient was again subjected to study for malabsorption syndrome. Her stools were negative for ova and parasites, and her intestinal absorption was normal. Review of previous gastrointestinal x-rays from the other hospital was not helpful. A diagnosis of malignancy of the pancreas was considered and Dr. Conn was called to see the patient. He detected a bruit in the epigastric area approximately two finger breadths below the xiphoid localized to a small area just slightly to the left of midline. Because of this finding the patient was subjected to aortography.

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m., alternating between the staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on May 18, 1968.

Dr. Hirsch Handmaker: A catheter aortogram was performed via a retrograde femoral approach. The take-off of the celiac axis is well demonstrated in several projections, revealing a marked narrowing of that vessel, just distal to its origin. There also is post-stenotic dilatation. The splenic and hepatic arteries were visualized and normal in appearance (Fig. 1).

Fig. 1: Aortogram demonstrating segment of stenosis and post-stenotic dilatation of the celiac axis (arrow).



Dr. John Beal: Where is the superior mesenteric artery?

Dr. Handmaker: The superior mesenteric artery is best seen in a lateral projection film and does arise separately from the celiac. It is normal in appearance except for a more acute angle take-off than is usually seen.

Dr. Julius Conn: It has been classically taught that there had to be involvement of two of the three major intestinal arteries in order to develop the intestinal angina syndrome. We are now seeing increasing numbers of patients with stenosis of a single artery who have signs and symptoms of chronic intestinal ischemia.

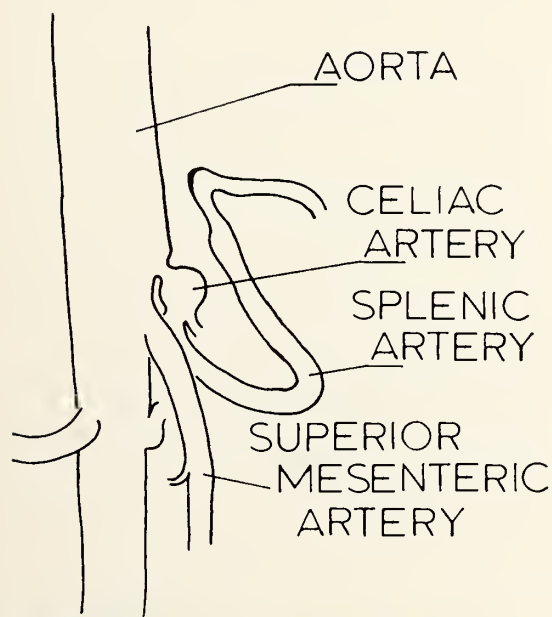


Fig. 2: Diagram outlines vascular distribution of aortogram.

The celiac compression syndrome is the third new syndrome that has come out of the state of Ohio in recent years. It was described by Marable and his associates in 1965.^{1,2} This syndrome occurs in young females who have compression of the celiac artery by the median arcuate ligament of the diaphragm. The celiac artery is held down along the course of the aorta by bands of muscle and fibrous tissue. On the arteriograms the celiac axis appears to originate with the superior mesenteric artery

although it arises proximally. This is one of the characteristic x-ray findings and explains the problem of identifying the superior mesenteric artery on the x-rays. If you fail to see the stenosis, seeing the celiac and superior mesenteric artery superimposed on each other should alert you to the diagnosis.

In our own series of patients with intestinal ischemia we have had six patients with chronic occlusion of the celiac artery and three with occlusion of the superior mesenteric artery. Of the six patients with celiac stenosis, two had extrinsic compression and four had arteriosclerotic occlusions. These patients characteristically presented with marked weight loss, averaging 40 pounds. All of our patients have had postprandial abdominal pain. They have been subjected to extensive work-ups and have been on many medications.

We found that today's patient has been on 14 different medications, both mood elevators, appetite increasers, and various tranquilizers, both for her intestinal tract and her central nervous system. On physical examination she had a very sharply localized bruit just below the xiphoid. Many patients will have bruits over the abdomen, but the vast majority of these bruits are transmitted down the aorta and are related to sclerotic plaques in the aorta. However, in this patient if the stethoscope was moved a centimeter in any direction the bruit would disappear.

The most significant finding in reviewing the intestinal ischemia syndrome has been the lack of laboratory and physical findings that can be put together to make the diagnosis. Many have had diarrhea, foamy stools, as this woman had, without the laboratory findings of malabsorption. Therefore, an arteriogram is essential in making the diagnosis.

On the basis of the arteriograms we felt that this patient had extrinsic compression of the celiac artery. The celiac axis was explored through the gastro-hepatic ligament and was found to be bound down by muscle fibers from the diaphragm approximately 1 cm from its origin. A very distinct thrill could be felt over the splenic and hepatic arteries. The superior mesenteric artery was quite close but was not involved by this process. As the muscle was cut away there was seen to be small fib-

rous bands extending across the artery also. In addition, there was considerable adventitial binding between the celiac artery and the aorta. The artery was dissected free and the thrill disappeared even though the area of post-stenotic dilatation persisted. The remainder of the exploration of the abdomen was completely negative.

Postoperatively she was started on oral alimentation on the second postoperative day and has progressed to general diet. She has had no further post-prandial abdominal pain or diarrhea. We encountered one problem postoperatively. On the fourth postoperative day she developed a pulse of 160, fever, rhinorrhea, agitation, confusion, and became disoriented. At first we thought that this was a postoperative psychosis, but it became apparent that she was having acute drug withdrawal symptoms; probably due to the large quantity of opiates she was taking because of her diarrhea and pain before surgery. She was placed on Demerol and Librium, has been slowly withdrawn and has no further problems.

Dr. John Bergan: This is the same interesting syndrome that Dr. John Olwin showed at the Chicago Surgical Society a year ago. He pointed out the salient diagnostic features at that time. It is worth emphasizing that this was a golf course diagnosis by Dr. Conn. The internist with whom he was playing was grousing about a patient with psychoneurotic weight loss. Dr. Conn put the important facts together and suggested that the diagnosis could be made by a simple expedient of angiography. I think the correct diagnosis can be made over the telephone as well. The thing that is significant to me is that there are large gastroenterologic services in excellent hospitals in the city of Chicago which have never encountered this interesting syndrome. Yet just yesterday we saw but still another case at this hospital. This is an infrequent diagnosis. I am sure it is missed too often in young women with weight loss who have rather nonspecific complaints.

Dr. Otto Trippel: This syndrome may be quite rare or it might be that many physicians are not aware of these patients. If this diagnosis is kept in mind by doctors

in general, many young persons can be relieved of significant distress.

Dr. Peter Rosi: Dr. Bergan and I did have one patient of this sort in 1965 at Veterans Administration Research Hospital who had similar complaints and angiographic findings. When we dissected out the celiac artery and cut investing bands, the aorto-celiac pressure gradient disappeared and the patient was relieved of his symptoms.

Dr. Beal: Now, it seems to me that the only way you can make the diagnosis is really by arteriography. Upper abdominal pain in young females is not an infrequent complaint. Does this mean all young women who have upper abdominal pain ought to have aortograms?

Dr. Conn: I think patients who have persistent abdominal pain and weight loss and who have had complete evaluation should have an arteriogram, especially if an abdominal bruit is present. Arteriography is a reliable test with minimal morbidity and can be quite revealing. Celiac compression has been described in patients as young as 13 years of age and as old as 60. One disturbing fact is that Dr. Wylie at the University of California found two patients with celiac artery compression as an incidental finding while visualizing the renal arteries.³ Therefore, I don't think that x-ray findings alone are enough to operate upon.

Dr. Beal: Did they all have bruits?

Dr. Conn: All of our patients have had bruits and I believe 25 of 30 of Marable's had bruits. I don't think there is a good explanation for the diarrhea. There is certainly evidence of malabsorption. As for the weight loss, it is purely mechanical. These people have pain when they eat and therefore they eat less.

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Two Year Experience With Electro-Convulsive Therapy In A Semi-Rural Hospital

By IRVING FRANK, M.D., Ed D., ROSANNE K. FRANK, R.N., M.S.,
AND JOHN R. JOHNSON, B.A., F.A.C.H.A./SYCAMORE

Two years ago an approach was made to the medical and administrative staff of our local hospital with a proposal that we attempt to treat emotionally disturbed patients. We felt that within the framework of the new concepts of comprehensive medicine, the psychiatric aspects of patient care should be available, along with the physiological. There was general agreement that we were in a position to offer psychiatric services not available elsewhere in our county. Since the closest facilities were located at such distance that it meant serious separation and disruption for the families involved, some planning for care at the local level seemed a vital need. This paper deals with only one modality in the total care of the emotionally disturbed patient. The criteria for its use will be briefly discussed.

Our 70 bed, approved, short term general hospital is situated in a semi-rural area. While there is some industry, we are primarily a grain raising and stock feeding community. The medical staff is composed of general practitioners.

The population of this study consists of 39 patients treated in the last two years.



Irving Frank, M.D., Ed.D., is a graduate of the Chicago Medical School. He served his internship at St. Joseph's Hospital, Bellingham, Wash. and later earned his Ed.D. in Educational Psychology from Northern Illinois University. He is engaged in private general practice

with emphasis on internal medicine and psychiatry. He is presently a clinical associate in the Department of Neurology and Psychiatry, Chicago Medical School. Mrs. Rosanne K. Frank, R.N., M.S., is an instructor in the School of Nursing, Northern Illinois University. She received her R.N. from Cook County School of Nursing and an M.S. from NIU in guidance and counseling. John R. Johnson (not pictured) is administrator of Sycamore Municipal Hospital.

They are predominantly white, Protestant, Anglo-Saxon in origin, and range in age from 21 to 74. They are employed, in the main, in factories or on farms, a few being housewives. Most of the patients had a high school education, with the exception of one who was a teacher. Most of the time these people came to their family physician with physiological complaints. It was when the physician became aware of the depressive overlay that they were then evaluated for this type of treatment.

Objectives of Treatment

In the care of patients with emotional illness one must assume that there exist specific indications for a treatment of choice, just as in any organic disease entity. By a like token, one must have certain definite objectives in mind for the use of a particular modality. Therefore, our objectives specifically were:

1) In a crisis oriented frame of reference it was hoped that we could shorten the period of hospitalization thus reducing the period of physical and mental suffering;

2) To try to return the patient to his previous social role, with the least economic loss.

Criteria for Choice of Therapy

Historical and empirical evidence has shown that in selective cases electroconvulsive therapy is of definite value. The question can, however, legitimately be asked why, for certain patients, was this felt to be a proper form of therapy, but unsuitable for others? To understand this choice one must recognize that we were dealing primarily with depressive reactions, usually secondary to some other life situations. It is our feeling that, by and large, this is the category of patient most frequently seen by the generalist. His first approach should be a conservative one—by this we mean the use of psychotropic drugs, combined with some form of counseling, either of a directive or non-directive psy-

chological approach. After a sufficient trial—which can arbitrarily be set at two months' duration, if no improvement is observed then a re-evaluation must be done, with a consideration to the use of electro-convulsive therapy (ECT).

Again we wish to stress the fact that electro-convulsive therapy should be considered as just *one* of the modalities in the armamentarium in the physician's treatment of the emotionally ill. There is a second category, however; that of the patient in an acute depressive crisis with strong suicidal tendencies for whom this is the treatment of choice *immediately*. Very often, for social, cultural, or personal preferences, such a patient cannot be moved to a large institution devoted solely to the care of the mentally ill. For this individual the use of ECT in the local, general hospital may be a life-saving device.

Generally the following are accepted indications for the use of electro-convulsive therapy:

- 1) The functional psychoses, schizophrenia, manic depressive reactions, and the so-called involuntional psychoses of middle and later life.

- 2) When the patient's grasp of reality is so distorted that he cannot be reached with psycho-therapy.

- 3) In the presence of severe agitation, or manic excitement, catatonic withdrawal, or depressive stupor, strong suicidal urges, and malnourishment due to refusal of food. These may constitute virtual emergencies for the use of electro-convulsive treatment.

- 4) Depressive reactions where the patient shows a general physiological slowing down, insomnia, with awakening about 3-4 a.m. and daily mood swings with the deepest depressions occurring in the pre-dawn hours.

- 5) In recent times electro-convulsive therapy has been used in those patients with severe agitation, depression, or excited states associated with arterio-sclerosis or senility—*age does not constitute a contraindication*.

- 6) Those patients suffering a true depressive reaction, who after a period of psycho-therapy and drug therapy are still suffering, and unable to perform their usual work, in which there is serious interference with their usual personal and economic life.

Methods of Treatment and Procedures

Being a small general hospital it was impossible to set aside a whole unit for a specialized service such as this, so the psychiatric patients were admitted on the same basis as any others. There was no attempt to isolate the psychiatric patient from the general population of the hospital. We found, however, after some experimentation, that it *was* more expedient to remove the patient to a special treatment room for the actual electro-convulsive therapy procedure. Our procedure was as follows:

- 1) Every patient received routine laboratory measures such as CBC, blood chemistry, ECG and chest X-rays.
- 2) One hour before treatment, patient was given 1/150 gr. Atropine, I.M.
- 3) Patients are given 10 to 20 cc. of 5% Pentothal I.V., with a 0.5 to 1 cc. of a muscle relaxant (Anectine), which produced a light anaesthesia.
- 4) All patients received 130 volts for one-half second (0.5 seconds) duration, producing convulsive effects.
- 5) The individuals were carted back to their rooms as soon as full respiration was restored. It was usually a matter of 10 to 15 minutes before they were responding adequately.

Post ECT Treatment

A nurse or an aid stays with the patient when returned from the treatment room. The patient's blood pressure, pulse, and respiration are recorded every 15 minutes. The attendant remains at the bedside until the patient is fully awake. We found that this takes about 45 minutes for most patients. The nurses were trained to make psychiatric observations and record any behavioral responses.

Of course, all of these hospitalized patients were seen for follow-up, subsequently, in the office, where brief forms of psycho-therapy were used and drugs were administered.

Personnel Education

Before attempting a psychiatric service, we felt that it would be wise to survey the attitudes and feelings of the nursing staff participating in such a project. Not surprisingly, we found several who were totally disinterested and even hostile to playing any role with emotionally disturbed

patients. We therefore chose to work, in the very beginning, only with those staff members who had indicated positive interest. With this group we started an educational program to acquaint them with what we were trying to do, the rationale for this methodology and the hoped for results. The physician member of this reporting team included a brief discussion of the clinical diagnosis and attempted to give them a clear explanation of the psychopathology involved. It was hoped that this educational approach would result in more active involvement of the nursing staff at all levels.

Medical Personnel Involved in Care

It is the feeling of the medical author of this report that in the absence of a psychiatrist, those physicians who have a psychiatric orientation and interest can function very adequately in the management of these patients. We are fully aware of the fact that those who are seriously disturbed should be referred to our colleagues who specialize in psychiatry. What we are concerned with, here, is the large number of neurotic patients whom we see in our offices with presenting complaints which are temporarily extremely incapacitating. Here a crisis oriented, short term of hospitalization will in most cases suffice to return a breadwinner to his job, or help a housewife resume her household duties.

A physician who is sufficiently motivated to participate in this comprehensive approach to medicine can prepare himself by attending lectures such as those given regularly by the American Academy of General Practice, or by attending courses given by medical schools in his area. These are usually under the sponsorship of the departments of Psychiatry. A good many medical schools include these types of courses in their continuing education programs. For a detailed description of these one has only to contact the American Medical Association or the Illinois State Medical Society. If you are fortunate enough to be close to a mental hospital, there are all sorts of arrangements that can be made for learning experiences, feasible within the framework of a general practice.

Hospital Administrator's Concerns

Grass root concern for the care of our emotionally ill at the local level is expanding. The administrator member of our

team recognized that certain types of emotional illness could well be cared for in our local hospital. With more and more hospitalization plans carrying coverage for this aspect of health problems, he found that insurance claims were not refused for a diagnosis involving mental or emotional disorders. It is becoming obvious that this is simply another basic care area for general hospitals to maintain. It can be absorbed in the general routine of caring for patients without penalty of increased professional malpractice insurance premium rates, or more sophisticated facilities.

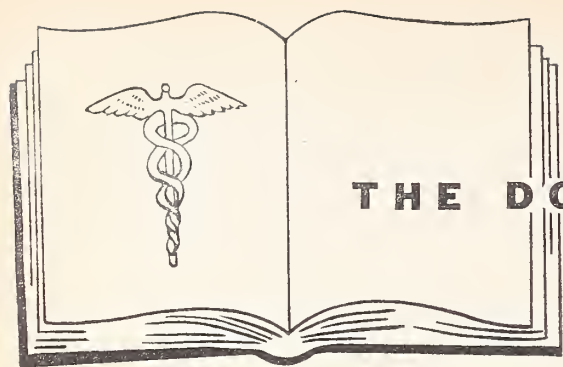
Summary and Conclusions

- 1) Patients were kept in their own community, close to home.
- 2) The stigma of mental institutionalization was avoided.
- 3) The hospital stay was shortened.
- 4) In-service education resulted in the involvement of the nursing staff, with resultant strengthening of positive attitudes toward mental illness. Their psychiatric orientation resulted in more intelligent charting for all hospitalized patients.
- 5) The general acceptance and involvement of the community and hospital medical staff with mental illness. (We feel that this community involvement was a decisive factor in our recent referendum by which we voted to tax ourselves to establish a mental health center in DeKalb County.)
- 6) Marked improvement in 40% of the patients.
Moderate improvement in 40% of the patients.
Mild to none improvement in 20% of the patients.
- 7) Summarizing our 2 year period of experience with depressed patients we can honestly say that the care of some mentally ill people can be successfully carried out in a small general hospital under the supervision of a psychiatrically oriented general practitioner.

At the end of this two year experience we now have a most cooperative nursing staff with whom it is a pleasure to work in the area of giving psychiatric care in our community.

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BURNS, SHOCK, AND PLASMA VOLUME REGULATION, Carl A. Moyer and Harvey R. Butcher. C. V. Mosby Company, St. Louis. \$18.50.

The authors state in their preface, "We hope that if this book accomplishes nothing else, it will at least serve to heighten the physician's sense of therapeutic ignorance and ministrational inadequacy in the areas of shock and burns." This candid goal is accomplished well. The book is comprised of three parts and contains 365 pages of text and illustrations. There is a 65 page appendix which contains graphic illustrations of experiments described in the text.

The first section of the book is one chapter entitled "An Understanding of the Factors Influencing Blood Volume Regulation." On the first page, the authors state the current beliefs held by most physiologists and clinicians, namely that in the restoration of blood volume following acute simple hemorrhagic oligemia (hemorrhage unassociated with tissue injury) the colloid osmotic pressure of the blood must be increased to increase the blood volume, and that blood volume can only be increased to a limited degree using a protein free fluid. After the presentation of this thesis, the antithesis is developed beginning with the historical proponents (Darrow and Yannet, 1935) of the direct quantitative relationship between plasma volume and corporeal sodium mass. Sodium depletion studies on humans, within the range of sodium deprivation compatible with adequate circulation in man, reveal a proportional diminution in measured blood volume to sodium depletion. Furthermore, there was a proportional increase in the measured protein and red cell concentrations in the patients with sodium deple-

tion. There is not enough data currently to formulate a proper theory of blood volume control. The hypothesis of plasma volume regulation proposed by these authors is a general theory involving "the relationship of change in plasma and blood volume to positive and negative loadings of water, inorganic ions, organic macromolecules, and red blood cells during hyperosmolar, isosmolar, and hyposmolar dehydrations."

The second section of the book is devoted to hemorrhagic and dehydrational shock. There are three chapters in this section. The first is a concise history of treatment of hemorrhagic shock. The second chapter on hemorrhage and dehydrational shock is on the bioassay of therapeutic techniques in shock. Experimental protocols are presented and experimental data reviewed. Conclusions are then drawn. "The demonstrated superiority of giving blood together with lactated Ringer's solution over giving blood alone in treating hemorrhagic shock . . . the transfusion of blood is an indispensable part of the treatment of hemorrhagic shock. . . ." The enormous void of information about the relationships of extracellular and intracellular ions, enzymes, hormones, hydration of macromolecules, is emphasized and the conclusion to this discussion is "basically we know practically nothing about shock." The last chapter on shock is entitled "Dehydrational Shock." The major emphasis is on sodium deficit shock and how this affects oxygen consumption, urine sodium concentration, physical signs, serum concentration, hematocrit, and serum protein determinations.

The third part of the book is on Burns and Burn Shock. This also comprises the largest volume of the book. The first two

chapters are on the physiology of skin and specifically the cutaneous barrier to water vapor transpiration. The component parts of the skin and their contribution to normal skin's remarkable efficiency in maintaining fluids are analyzed.

The next chapter is Bacteriology and Bacteriostasis of Burns. The authors describe their method for quantitating the degree of infection in a burn. They also present their considerable success with thick gauze dressings kept continuously wet with a solution of 0.5% aqueous silver nitrate.

The last major chapter is on the clinical area of the burned wound and incorpo-

rates the ideas and principles introduced earlier.

This book contains the historical, scientific, and clinical experience of outstanding leaders in the area of burns and shock. Why they investigated the many unknown factors of shock and the results of their investigations are made clear. The inadequacies of many currently accepted empirical teachings in this field are wittily and dogmatically emphasized. The book is an exciting book and should be essential reading for those with a special interest in these areas.

Paul H. O'Brien, M.D.

Medic Alert May Save Many Patients' Lives

An incredibly simple yet effective little device—a metal emblem—could mean the difference between life or death for the patients of physicians in many specialties.

The potential silent lifeguard is the internationally recognized emblem of the Medic Alert Foundation International, a nonprofit, charitable organization headquartered in Turlock, Calif.

The amulet, worn as a bracelet or necklace, alerts doctors, nurses and other personnel attending emergency cases to the wearer's hidden or special medical problem.

On the face of the emblem are the words "Medic Alert" and the familiar snake-encircled staff of Aesculapius in bright red. The back is engraved with the wearer's Medic Alert membership number; the telephone number of Medic Alert's Central File in Turlock, which physicians and other authorized personnel may call on a collect, 24-hour basis; and a warning, such as "Allergic to penicillin."

Medic Alert is dedicated to preventing inadvertent medical ministrations that could have fatal effects. Very often when a patient is rushed to a hospital emergency ward suffering from multiple traumatic injuries, there is little time to do anything but the expedient. The bleeding must be stopped and infection prevented. Allergies, hypersensitivities or other special conditions could easily be overlooked.

But if a patient has an allergy to penicillin or a hypersensitivity to other drugs, a dose intended to cure could kill. If the patient has a cardiovascular disorder he may be taking anticoagulants which must

be counteracted by the administration of other drugs. Inadvertent failure to take the right steps could prove fatal.

More obviously, diabetics and epileptics should wear the protective Medic Alert insignia. Persons with these afflictions can easily—and often are—mistaken as drunk and end up in the local jail with tragic results.

Today, more than 200,000 Americans wear the protective Medic Alert medallion, and the Foundation receives more than 2,500 new enrollments every month.

Medic Alert has affiliates in 11 foreign countries and has been endorsed by a large number of county and state medical societies and by many national organizations, including the American Academy of General Practice, the American College of Allergists and the American Academy of Allergy.

There are more than 200 known reasons for wearing emergency medical identification and these are seen in nearly every medical specialty.

The physician has merely to recommend enrollment in Medic Alert. No prescription is necessary and there is no paper work incumbent upon the doctor. Medic Alert will supply physicians, free of charge, attractive canisters containing membership application blanks by writing Medic Alert, Turlock, Calif. 95380.

A membership, including an emblem, a medical wallet card and round-the-clock information service, is available for a lifetime membership fee of \$7, or free to the needy.

Medical Management Of Acute Alcoholism

By ROBERT A. MOORE, M.D./ROCKFORD

Medical management of the acute phase of chronic alcoholism is a vital beginning to eventual rehabilitation. It is the one point in the treatment of chronic alcoholism where the physician has the greatest responsibility and where his special skills can be best utilized. It should be the time when he is most comfortable in his contact with his alcoholic patients, but unfortunately it often turns out not to be this way.

The reluctance of the medical profession to accept responsibility for the alcoholic patient is well known. Various rationalizations are given for this including such things as that the patients are uncooperative, are a nuisance once admitted to the hospital, cannot be "unloaded" when the acute phase is terminated, do not pay their hospital or medical bills, etc. We recognize that these rational statements are most likely a cover up for ones less rational. The doctor, being no different than his fellow citizens, has many unconscious attitudes towards the chronic alcoholic that make it difficult for him to accept him as an equal with other patients who are no more ill.^{1,2} Educational efforts for the general public as well as physicians may in time expose attitudes of envy and disgust to the individual who holds them, but this is not the issue of our discussion. Another unstated problem is the lack of confidence of the physician that he will know how to handle the alcoholic patient. This might seem surprising considering the number of acutely

ill people he treats with relative comfort, whose conditions require much more complex considerations.

If physicians were more sure of themselves in working with the acutely intoxicated person, this would encourage them to accept such patients more readily. Once having had a taste of the treatment of alcoholism, they might find themselves becoming quite interested as they recognize how much actually can be done. Although they might at this point refer the patient after the recovery from the acute phase to some other resource, inevitably they will have an interest in the rehabilitation value of certain resources and will take some responsibility in encouraging the development of better resources.

Guidelines Requested

At the Swedish-American Hospital, Rockford, this problem resulted in the staff asking for a regimen for evaluation and treatment of the acutely intoxicated patients coming into the emergency room. Some opposition was expressed, namely that this would lead to a "cookbook" treatment approach. The counterargument was that each physician would be able to use his own clinical judgment and take or reject suggestions in the regimen. The majority of physicians were pleased to have these suggestions available to them.

That this step did not solve the problem will be demonstrated by one example:

A 55 year old factory worker was admitted to the medical floor by his physician, a very competent and experienced internist. He had been calling the police repeatedly prior to his admission, because of visual hallucinatory people, animals, and insects that were coming into his home. The patient was known to be an alcoholic to the physician but had not previously had any care for this condition. About 24 hours after his admission I was called in consultation. By this time he had created considerable anxiety by twice wandering from the hospital

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bed, once getting as far as the parking lot in his pajamas. He was agitated, terrified, pulling off his clothes, and a serious nursing problem. One can understand this when it was discovered that his total medication since admission had consisted of one 100 mg. injection of Sparine. Further, he had been put in a small ward where he was an object of ridicule of the visitors to the other patients, largely ignored by the nursing staff, and his "crazy questions" were left unanswered. With proper management and medication (to be discussed later), the patient made an uneventful recovery and eventually left the hospital to begin the hardest part of his rehabilitation, namely the treatment of the chronic phase of alcoholism.

One of the unfortunate effects of this case came to attention a few days later when talking to a group of student nurses. It had created in them a feeling of helplessness in caring for such a situation, which crystallized in their minds the belief that patients of this sort should immediately be moved into the psychiatric division and that responsibility not be left in the hands of general duty nurses. Thus, what could be a relatively routine problem which nurses could learn to handle in their general sense of competency became something of an overwhelming problem.

Initial Need for Treatment Described

This discussion is to be directed at the hospital management of acute alcoholism, recognizing that many patients do not need hospital care. Some acutely alcoholic patients are obvious candidates for admission, certainly those that are comatose or nearly so. However, for purely medical reasons, certain still conscious alcoholic patients should be admitted. These would include those who are vomiting and threatening severe dehydration, those who come to medical attention so intoxicated that they may fall and harm themselves, those who show other illnesses or injury serious enough to require general hospital observation irrespective of their alcoholism, those who are markedly tremulous or hallucinated, and those who have a history of convulsions within a few days prior to the present episode. Psychiatric indications for admission would include those alcoholics who are threatening suicide or injury to others

and those for whom a cessation in their drinking pattern can only be accomplished while forcibly made abstinent.

These criteria exclude the alcoholic who is simply intoxicated, with no threatening complications, and who has a home and family who can maintain him. For him sleeping off the drunk is the best treatment.

Legal Considerations

This problem has certain legal overtones which may become more imperative in the near future. Up 'till the present time, most communities have handled their "drunks" by placing them in the county or city jail. Recent court decisions, such as the Easter and Driver cases may soon result in a far-reaching Supreme Court decision making this an infringement on basic civil rights. When that time comes, jails cannot be the recipients of "drunks," only hospitals. Thus, it behooves every hospital to prepare itself for this day by establishing certain criteria and regimens for care so that the staff will be practiced in this area before being deluged.

Where to Put the Patient

If a hospital has no psychiatric division, the question where to put the patient is of no great concern. Where psychiatric divisions exist, there usually is considerable acrimony about this. Psychiatrists feel the patient should be in a medical bed: other physicians feel the patient should be in a psychiatric bed. Obviously, the condition of the patient will have to be the determining factor. If a patient is unable to care for himself physically, sick enough to require bedside nursing care or threatening serious medical complications, he should be in a medical bed. If his hospitalization is not because of severe intoxication but rather to contain him from self-destructive behavior or to help him maintain abstinence, then the psychiatric division would be the place for him. Certain hospitals have set aside sections for the treatment of alcoholism and probably this is the ideal arrangement where space and staff interest allows. Others have established a small section, perhaps only two or three beds, for the receiving of severely intoxicated people who are then moved out of this small section twelve to twenty-four hours later to a regular medical bed or to the psychiatric section.

Examination and Testing

Examination of the acutely alcoholic patient presents no special problems. Certainly a brief neurological examination to rule out gross evidence of a head injury such as a subdural hematoma suffered from a fall, is essential. Beyond that, the general physical examination with special concern for the ruling out of respiratory infection and dehydration need no special mention. There may be differences of opinion about the extent to which laboratory studies are essential. If the patient is comatose or nearly so certainly electrolyte and blood gas studies are indicated. In the patient not so ill, however, laboratory studies certainly should include the usual CBC, urinalysis, and chest x-ray. Beyond that there is difference of opinion as to whether a blood sugar, blood urea nitrogen, and certain liver tests should be done. A very high proportion of patients will show elevated liver studies such as the transaminase shortly after a drinking bout, and its value as a screening test is questionable. On the other hand, the BSP test at this time seems a bit more than needed and it might be left for a few days after the severe intoxication. Serum amylase studies are done if there is serious abdominal complaints and other tests are done as indicated.

Treatment

Treatment of the comatose patient requires the usual medical supportive measures. If this comatose state seems to be more than a fleeting one, the patient should be cared for in the Intensive Care Unit where closer observation can be maintained. Here, vital signs are carefully watched and electrolyte and blood gas studies are repeated as necessary to maintain hydration and proper electrolyte balance. Obviously, no sedatives nor tranquilizers should be given at this time. Some feel that if there is significant evidence of cerebral edema that steroids should be given but there is opinion to the contrary.³

The real concern is not for the comatose patient who represents but a small portion of the acutely alcoholic, but for the patient who is in severe intoxication but not unconscious. This would include the tremulous or hallucinated and the patient in delirium tremens. In these cases the main issue is proper sedation.

Probably nowhere else in the care of the alcoholic is there as much difference of opinion as on this point. In the "old days," such drugs as paraldehyde and chloral hydrate were the standbys⁴ but not today.⁵ The best justification for this is that paraldehyde and chloral hydrate in their metabolism so closely resemble the metabolism of alcohol as to suggest that this is merely putting off the eventual necessary withdrawal. Alcohol itself is no longer suggested as a means of reducing severe withdrawal reaction. However, a recent study comparing paraldehyde and chloral hydrate with Librium, Sparine, and alcohol itself showed the use of paraldehyde and chloral hydrate to give best results.⁶ This included the giving of 10 cc. of paraldehyde orally or intramuscularly every four hours and a half to a gram of chloral hydrate every six hours.

However, this probably represents a minority opinion. The bulk of physicians working with alcoholics now seem to favor Librium (chlordiozepoxide).^{5,7-15} Librium has the special advantage of allowing the patient to be arousable for certain vital activities and further, because of its anti-convulsant activity, may be helpful in preventing withdrawal seizures. Those who have not been impressed with Librium may not be using it in adequate dosage. Adequate dosage would be 100 mg. intramuscularly immediately, repeated in one hour if necessary, and then repeated perhaps every six hours for the first twenty-four hours. After this, ordinarily, the patient can take Librium orally in the range of 25 mg. q.i.d. Doctors with prolonged experience, as Kendis of St. Louis,¹⁰ would suggest a regimen such as this, as would many others.

How deep the patient should be kept is open to some question. There is a certain opinion that the patient should not be oversedated because of the possibility of rather unexpected respiratory distress because of the synergism of sedatives and alcohol. On the other hand, such an expert as Bates believes that sleep is the best thing for these patients as he emphasizes that "doctors don't detoxify alcoholics, livers do."¹⁶ Thus, he advocates the use of intravenous barbiturates for at least eight hours of deep sleep after admission and longer if necessary.

Other sedatives and tranquilizing drugs have been recommended such as Vistaril (hydroxyzine pamoate).^{17,18} The pheno-

thiazine tranquilizers are somewhat out of style now because of their potential hepatotoxic effects and the other side effects that they can cause, some of which are not tolerated too well by a debilitated patient of this sort.

Grand mal seizures can occur in these patients. The use of Dilantin (diphenylhydantoin) and phenobarbital in those with a previous history of "rum fits" is suggested.¹⁹ We feel there is no point in the patient having his first seizures and thus routinely give 250 mg. of Dilantin IM at the time of admission, then 100 mg. orally t.i.d., along with phenobarbital usually 32 mg. q.i.d.

Concern About Hydration

The concern about fluids in alcoholics has gone full circle. It was once felt that overhydration was the major cause of serious complications and treatment was to remove a certain volume of spinal fluid. This was followed by a belief that dehydration was a serious problem since the patients so often stated they were very thirsty. This attitude was also encouraged by the belief that alcohol had a diuretic effect. More recent studies have shown, however, that alcohol is diuretic only in that phase when the blood alcohol level is rising. However, when the concentration of blood alcohol remains at a constant level or when it is decreasing, an anti-diuresis ensues which results in an expanded total body water reflected in all fluid compartments.²⁰⁻²² This is an isosmotic expansion with the increase in body water being accompanied by retention of sodium, potassium, and chloride. The one ion which is not retained, however, is magnesium²³ and some feel that magnesium sulfate should be provided patients at this point, especially if there are tremors or other evidence of central nervous system irritability. A 50% solution of magnesium sulfate given intramuscularly every six hours in the amount of two cc. can be given until the patient is eating well.²⁴ This is assuming an adequate liver function. However, as long as the patient is not vomiting, intravenous fluids and electrolytes are not indicated, in fact are contraindicated. Some feel that fluid should be pushed on the patient but others feel that the water fountain or juices should be made available to the patient *ad lib* with the assumption that he will take the

amount that he needs based on his feelings of thirst.

Vitamin Deficiency

One last "purely medical" issue would be the use of high potency vitamins. The most important thing is getting the patient to eat again, assuming he does not have obvious and serious vitamin deficiency. It has been our habit to give oral supplements of high potency broad spectrum vitamins but we have not used injectable vitamins unless there are obvious deficiencies. Rather, our hope is to get the patient eating again.

If a patient is hallucinated or threatening delirium tremens certain rules of management are essential. Recalling the poor example cited earlier, adequate medication is an obvious first. Further, the patient should be in a private room where he can be watched carefully. If members of the nursing staff are not available to be with him more or less constantly, then family members or an Alcoholics Anonymous "babysitter" should be employed. The room should be well lit, not dark, to avoid ambiguity of stimuli. The patient's frantic questions should be answered immediately. He should not be restrained.

Attitudes of Vital Importance

The attitude of the physicians and nurses is of vital importance. Disdain or criticism, fear of the patient, or indifference, will merely aggravate the problem. If the physician has an active interest in the recovery of this patient, with a hopeful anticipation, the nursing staff will share this. No special training is necessary for the nurses as long as they have some idea of what is expected, have confidence in the physician who is setting the regimen, and believe that this patient is as important to them as any other equally ill patient. If there is a psychiatric section in the hospital, and if it is felt this patient is too sick medically for that section, then nursing personnel from the psychiatric unit might come in as "consultants" to help the general floor nurses.

Summary

What we have been talking about is the easiest part of treating the alcoholic. It also is the part where our success is the greatest since here is where our general medical knowledge has most immediate re-

sults. These patients will get over their acute period, even if they have severe delirium tremens. It's the time after where the trouble comes, the rehabilitation program for the chronic phase. However, if the initial phase of treatment has been conducted with confidence and competence, the later treatment of the alcoholic will be much more successful. This is the chance to make that vital contact, the time when defenses of denial are not in action, when the desire for relief is greatest. When the patient says that he will never touch another drop, at this time he really means it. Our problem is keeping him meaning this.

Since discussion of the chronic phase of treatment is not the issue of this presentation, it will not be detailed. However, the physician has a considerable array of potential resources including Alcoholics Anonymous, psychiatrists, drugs such as An-tabuse, the clergy, halfway houses, psychiatric hospitals, and himself, if he has the interest of staying with these patients over the long haul.

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Learn By Experience

It has long been clear that clinical medicine can be learned only by experience. In effect, Nature provides practitioners with a continuous opportunity of self-education by means of the case method. Nature's post-graduate course is unplanned. However, over a period of time, and especially if practitioners take advantage of opportunities offered by attendance at clinical conferences, this kind of education produces able clinicians. (The Impossibility of Learning All of Medicine: What To Do About It. Mark D. Altschule, M.D. Commentaries. *Clinical Pediatrics* (April) 1968. 7:4;185.)

EDITORIALS



PULMONARY EMBOLISM

Pulmonary embolism is frequently seen in individuals over 40 and is the commonest single cause of death in elderly persons who have been injured. Necropsy studies revealed that deep vein thrombosis is prevalent among the latter. Many of these patients had no prior pain or swelling of the limb.

According to Sevitt,¹ pathologist at the Birmingham Accident Hospital, embolism was found in 40% to 60% of those who succumbed after fracturing the femur or tibia. It was the most common cause of death among them. Pulmonary Embolism was found in 27% of those dying after a fractured pelvis and 14% after a fractured spine. The incidence of pulmonary embolism is much lower among persons with head injuries, burns, and other trauma, possibly because they are younger.

Sevitt's controlled experiment using phenindione convinced him that susceptible persons should receive anticoagulants, prophylactically. In the control series of 150, embolism developed in 18 and fatal embolism in 10%. Embolism did not develop in

150 matched patients who were given phenindione. Furthermore, on reaching necropsy, many of those taking phenindione were completely free of thrombi of the lower venous tree. However, extensive involvement was found in the controls. Other investigators have confirmed these findings.

Since this study, anticoagulant prophylaxis is being used routinely in the high-risk injury group (over 40 and prolonged bed rest). Phenidione is started on the day of admission, provided there are no contraindications to anticoagulant therapy. An attempt is made to keep prothrombin activity between 18% and 25% of normal. Hip surgery is done, even though anticoagulants are used. Judging by the necropsy material, major embolism among this highly susceptible group has been lowered by more than 80%.

T. R. Van Dellen, M.D.

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BACK TO SCHOOL AFTER AN ILLNESS—GUESS WHEN?

Millions of children's school days are lost each year because of unnecessarily long convalescence at home following acute infectious diseases or symptoms simulating infectious diseases. This is a particularly serious problem because of the increasing educational demands on the school child of today.

A new look at the subject was directed

by Dr. Merrill A. Baratz of the Department of Pediatrics, Yale University School of Medicine.¹ He stated that parents, nurses and some pediatricians keep children home for needlessly long periods following acute infectious diseases. He states that children can be returned to school while on medication for "strep throats" and otitis media when the fever and pain have sub-

sided. Dr. Baratz feels that children with furunculosis, conjunctivitis, coughing, impetigo, ringworm and pin-worm infections can be safely returned to school on medication. We heartily concur with his views.

Another important cause of school absences, not mentioned by Dr. Baratz, are the symptoms simulating acute infectious diseases. Coughing, coryza, recurrent abdominal pain and chronic headache without evidence of fever or other signs of physical diseases are sufficient causes for some mothers to keep children out of school for lengthy periods. This can and does lead to school phobia in children. Several instances have been reported of children with chronic croup-like coughs who were kept out of school for weeks to months before a diagnosis of a psychogenic cough tic was made. It is important for each physician to be aware of the psychogenic nature of the complaints of school children.

Much more work will have to be carried out to find the optimal time for sending

children back to school. Although the time for sending children back to school is known for the classic contagious diseases, no set of guidelines exists for parents, teachers, nurses and physicians to follow for the many minor infectious diseases and symptoms simulating the onset of infectious diseases. This information is urgently needed. Until it is obtained, some parents will keep children with symptoms of a common cold home for a week, the school nurses will send home every child with a chronic cough due to mold allergy, and some physicians will keep a child with a "strep throat" home for a week.

Physicians should bend every effort to encourage parents to send their children to school as rapidly as possible after a disease, once the contagious period has passed.

H. Kravitz, M.D.

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Current Concepts of Toxemia of Pregnancy

BY W. R. MALONY, M.D., F.A.C.S./CARBONDALE

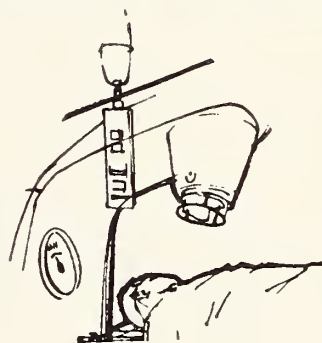
The toxemias of pregnancy are a group of pathological conditions occurring in pregnant, parturient and puerperal patients which have common findings of hypertension, proteinuria and edema, and commonly it is felt that the presence of any two of this triad is sufficient to make the diagnosis. Occasionally the presence of convulsions and coma is seen and death occasionally occurs.

The toxemias are classified according to Table I which is the classification recommended by the American Committee on Maternal Welfare. Other classifications are being discarded.

The incidence of toxemia is varied and dependent primarily upon the number of indigent primagravida patients handled in any particular area. In the United States the incidence is higher in the Southeastern states. The incidence is also higher than usual in China and India. During the past twenty years toxemia has been replaced as the number one cause of maternal death in the United States by hemorrhage.¹

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Medical Progress



HARVEY KRAVITZ, M.D.
Medical Progress Editor

**TABLE I.
CLASSIFICATION OF TOXEMIA**

- I. Acute Toxemia of Pregnancy
 - A. Preeclampsia
 - 1. Mild
 - 2. Severe
 - B. Eclampsia
- II. Chronic Hypertensive Vascular Disease
 - A. Chronic hypertensive vascular disease without superimposed acute toxemia.
 - 1. Cases in which hypertension is known to exist before the onset of pregnancy.
 - 2. Cases of hypertension before the 24th week of gestation.
- III. Recurrent Toxemia
- IV. Unclassified Toxemia

In the obstetrical services in Carbondale, during the last 4,032 deliveries the toxemias of pregnancy have been reported in 1.13% of patients.

A review of the statistics for 190 down-

state hospitals in Illinois over the same period of time shows the average incidence as 1.30% which is a very similar figure to the ones we have had in our services.

Forty-nine Chicago hospitals, during the same period, had an average of 2.44% toxemias of pregnancy reported.

TABLE II.
PERCENT OF TOXEMIAS

Carbondale, Illinois / 190	Downstate Hospitals
1.13%	1.30%
49 Chicago Hospitals	
2.44%	

It is felt that a much higher reported incidence in the Chicago Hospitals is probably due to the difference in the handling of patient's records. It is believed that the Chicago Hospitals probably have a much closer contact between the prenatal records and the hospital records at the time of delivery. In our experience, our prenatal records are forwarded to the hospital anywhere from two to six weeks before the date of delivery, and many patients exhibit a mild proteinuria with definite edema and/or slight elevation of blood pressure as they are seen in the office. These people are then put on treatment for early mild preeclampsia but this treatment does not exhibit itself on the hospital records, and for that reason the final diagnosis of the hospitalized patient does not include the diagnosis of preeclampsia.

In addition, there may be a certain difference in the percentage of people who obtain adequate prenatal care. We have very few patients of whatever sociological class or mental development who do not receive adequate prenatal care. It is possible that the metropolitan area comprising the "ghettos," for whatever reason, may have a considerably higher number of patients with little or no prenatal care.

At any rate, this is a sizeable number of patients and it does remain the number two cause of maternal death in the United States. For that reason it is worthwhile to keep abreast of investigative work being done and the current therapy. The day that a precise understanding of the pathology involved comes to us will be a happy day indeed.

And so to some changing concepts.

The work done by the Chicago Lying In Hospital on renal biopsies has changed

our concept of preeclampsia.² They have shown that there is a unique glomerular lesion believed to be pathognomonic of preeclampsia and eclampsia and they designate this "the toxic lesion." They appear to be able to differentiate between this toxic lesion and arteriolar sclerosis and chronic renal disease.

For this reason it now appears that preeclamptic toxemia of pregnancy occurs only in first pregnancies. It would seem that any of the recurrent or unclassified toxemias are probably on the basis of chronic renal disease and are not true preeclampsia-eclampsia. It would seem that the investigative work being done to arrive at the true pathology in the preeclamptic-eclamptic syndrome should be directed entirely toward the group with no history of previous cardiovascular renal involvement.

These patients are typically primagravida who are young and who have inadequate prenatal care. It must be recognized that at times the inadequate prenatal care is the patient's failure to follow the prenatal instructions given by their physician. Some young primagravida apparently find it extremely difficult to control their psychological reactions to pregnancy, and as a result end up with preeclamptic condition even though a good deal of time and effort is directed by their physicians and auxillary personnel in attempts to have these people regulate their activities in the proper manner.

It seems that at times the physician becomes more frustrated than the patient in trying to get young teenagers to follow proper diet, proper physical activity and proper psychosomatic adjustment to their environment.

The relationship between unusual sodium retention and generalized vasoconstriction is not known. The usual clinical observations indicate that sodium retention precedes vasoconstriction and prompt therapy frequently prevents the development of vasoconstriction. Since the thiazides have become available there has been a complete change in the concepts of treatment of toxemia. It would seem that the thiazide diuretics are at present the ideal therapy for sodium retention and their great asset lies in the fact that they can be given continuously in most patients without the problems of drug resistance. For that reason they are at times given in

the toxemia prone patient before evidence of real trouble occurs.

A very obvious advantage to the use of these medications is their ability to eliminate sodium retention while the patient still is allowed to enjoy a relatively normal diet as far as sodium is concerned.³

All sorts of reports have appeared concerning the advantage of one particular thiazide over another. It appears that Chlorthalidone (Hygroton) is actually a long-acting diuretic and antihypertensive agent which can be administered once a day. A single dose of 50 mg. of Chlorthalidone is usually followed by at least as good a diuresis as that produced by 500 mg. of Chlorothiazide twice a day.

Because of these facts, at the first appearance of preeclamptic symptoms in the parturient patient, the use of either Chlorthalidone once a day or one of the Chlorothiazides twice a day is now instituted. This has been of great help in handling these patients.

Manitol is a substance which is used intravenously to combat edema. It mobilizes fluid very effectively and it also causes the excretion of the sodium ion very effectively.

It has been used in a variety of conditions because of its unique and rapid action. It has not been reported as used in eclampsia or severe preeclampsia, to the best of my knowledge. However, it is suggested that this may be an effective therapeutic agent that has been neglected as far as its obstetrical possibilities are concerned. The medication should be used only intravenously and it is suggested that not over 100 grams be given in twenty-four hours to any particular patient, although this may be given much more rapidly. In the patients where it has been used, this dosage has at times been given in a span of ninety minutes.

The rennin angiotensin system has been extensively investigated as it is related to pregnancy and preeclampsia during recent years. It appears to be well established that in normal pregnancy a marked elevation of rennin occurs in the blood plasma. It is also well established that in normal pregnancy the blood pressure response to angiotensin is markedly decreased from the normal controls. Furthermore, it is now accepted that in the preeclamptic-eclamptic patient the responses and elevations return to or near the normal values.^{4,5}

The reasons for these findings are certainly not clear at the present time. It has been suggested that the increase in Progesterone content may affect the aldosterone secretions and thus cause the altered responses.⁶

It has also been suggested that the sodium content in the vascular walls may be the factor that is involved.⁷

Hodari has found that there is an increased concentration of rennin in the kidneys of fetuses born from toxemic dogs.⁸ Hodgkinson in his experiments with pregnant hypertensive banded dogs has also found that there is evidence suggesting that the control of maternal blood pressure during pregnancy is vested in the kidneys of the mother's developing fetus.⁹

Muresan and Zehan are investigating the effects of uterine overdistention as related to renal plasma flow, glomerular infiltrations rate and filtration fractions.¹⁰ Redd and associates¹¹ have noted that severely preeclamptic patients who are admitted to hospitals for therapy and are then available for investigative work are always put at bed rest. They pose the interesting question as to whether posture may be a factor in the development of preeclampsia. The suggestion is made that perhaps the people admitted to the hospital for treatment and investigation, instead of being put to bed, be kept up and about in order to maintain their usual postural influences and suggest a possibility that such procedures might gain additional information regarding the cause of the preeclamptic-eclamptic syndrome.

All of this is of tremendous interest but at the present time it is not known whether this work will actually lead to the discovery of the etiology of our problem or whether it is simply an additional lead that will not give us the final answer.

Recently there has been an upsurge of interest in fetal salvage in the toxemias of pregnancy. It is an accepted fact that the presence of toxemia markedly increases the number of fetuses lost. Efforts for salvage should certainly be continued and increased in intensity.

In conclusion, it can be stated that there are a few very interesting developments in the toxemias. At the present time no sensational information is forthcoming. Efforts to determine the actual etiology of preeclampsia must be continued.

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**medicine
in the
seventies**

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SCIENTIFIC SESSIONS

TECHNICAL EXHIBITS

HOUSE OF DELEGATES



Illinois Department Of Public Aid

Payment Procedures and Policies Explained

HAROLD O. SWANK, DIRECTOR
ILLINOIS DEPARTMENT OF PUBLIC AID

Part III of a Series.

Emphasis in this series of articles has been and will continue to be on helping physicians obtain more rapid and correct payment for their services by developing a greater degree of precision when billing the Illinois Department of Public Aid (IDPA) for medical services rendered to public aid recipients. The magnitude of the medical program—more than 600,000 medical bills processed monthly—dictates that processing and payment by Public Aid be a centralized, computer operation. In billing, care must be taken to *enter exactly all identifying case, patient, and physician data and to properly code the medical procedures*. Otherwise, the computer cannot match the bill with the appropriate case and individual physician profiles which are stored in the computer. The result—computer rejection and individual handling for research and connection—leads to delayed payment. Examples of improper or careless coding are to appear in future installments.

In this installment a medical bill will be traced—administratively—beginning with the first contact of doctor and patient, through the filling out of the IDPA form MS-132 (revised 1-1-67), "Physician's Statement of Services Rendered." Correct procedures will be pointed out as well as some of the more common errors.

Question: What is the first administrative step in the billing procedure?

Answer: The most basic criterion—if Public Aid is to be billed for a medical procedure—is that the patient be eligible

for public assistance. The point needs to be made because in the course of a month's time the Department receives many billings on patients ineligible for public medical assistance.

HAVE YOU A QUESTION?

Physicians' questions concerning IDPA methods, procedures and policies are solicited and will be answered in these articles or by direct communication. The Department is desirous of eliminating misunderstandings and to work cooperatively with Illinois physicians. Send questions to:

IDPA Editor
Illinois State Medical Society
360 N. Michigan Avenue
Chicago, Illinois 60601

Question: How does the physician determine the patient's eligibility?

Answer: The IDPA issues a case identification card (CID) for each public aid case naming every eligible person in the case. It is issued to the principal person in the case and his or her name appears in the block titled "case name." In single category cases—Old Age, Blind, or Disabled—it is the only name to appear whereas in Aid to Dependent Children cases, there will also be named all other eligible dependents in the case.

So, the doctor should physically check to make sure that the potential patient is named on an official CID, and that the

for medical assistance only (Title XIX) receive a CID which may be issued for as long as six months. *The important points are that the patient be named and the CID be unexpired.*

Question: Does a doctor encounter identification cards other than the ones issued by IDPA?

Answer: Yes. Very likely each doctor encounters a number of IDs since several governmental agencies issue them as do many private agencies which deal with individual or group health plans.

They come in a variety of colors, each designed to aid in quick though partial identification. To cite only a few: The IDPA issues a *green* CID, Social Security Medicare IDs are *blue and white* (and also show whether or not the bearer is eligible for hospital insurance only or for both hospital care and medical insurance), and General Assistance IDs are *pink* and may be issued to cover only a short span of time. The GA bill is to be paid by the local GA office, not by the IDPA.

Question: After establishing eligibility what is next?

Answer: In the accompanying sample of a CID and a billing form 132, note the similarity of the entry blocks. The doctor merely transfers the identification data on the CID to the corresponding blocks on the Form 132. Copy exactly the case number, group or township number, case name and address, and always list the patient's name. Remember, in Aged, Blind or Disabled cases, the case name and patient's name are the same since there is only one eligible person in the case. An ADC case is a multiple person household and the patient may either be the case name or a dependent listed in the subsidiary ADC block.

There is one other important identification—the doctor's own AMA Education Service number. An incorrect AMA number, or no number at all, results in the computer being unable to locate the doctor's profile in the storage tape. Similarly, incorrect case identification data results in the computer not locating the individual case profile.

Question: The importance, then, is precision of entry?

Answer: Yes. The information needed on Form 132 is both available and short—but it has to be exact. A not uncommon error stems from copying the identifying numbers from a previous bill for other services rendered the same patient. A per-

son's category of assistance can change and hence some of the identifying data. If such be the situation, the computer cannot match the bill to its new profile identity. So, only the numbers on a current CID should be used else needless delay may ensue.

Question: What is the purpose of listing the six types of visits on the upper half of Form 132?

Answer: IDPA simplified the billing procedure by pre-coding on the bill itself the six most common visit procedures. This pre-coding is for the convenience of the physician, thus eliminating the need to refer to the current *AMA Procedural Terminology* booklet on recurring procedures. Services coded on this portion of the form should not be repeated in Part II—"Report of Other Services."

Similarly, one will note that on the back of Form 132 there are listed some 60 of the more frequently used medical procedures. All others must be checked in the CPT booklet.

Question: What about dispensed drugs?

Answer: That's a frequently asked question. The guideline is printed on the back of Form 132, namely, "If the physician's statement is itemized to show the name, strength, or potency, and the quantity of the drug(s) for which a charge is made, payment shall be on the basis of the physician's charge or wholesale cost of the drug(s) plus an additional service charge for handling and breakage not to exceed 20 percent, whichever is less."

"If the statement is not itemized and shows only the name of the drug dispensed, payment shall be the amount charged or \$1.00, whichever is less."

Question: What about injectable drugs?

Answer: That, too, is covered on the back of Form 132. "Payment for injectable drugs administered by the physician on home or office visits shall be \$1.00 to cover the cost of the drug. When an expensive injectable is used and a charge of more than \$1.00 is made, the physician's statement shall be itemized to show the name of the drug, the strength or potency,

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
CASE IDENTIFICATION CARD

THIS CARD EXPIRES AFTER
DATE PRINTED BELOW.

CASE IDENTIFICATION NUMBER

GROUP OR
TOWNSHIP

THIS CARD
ISSUED TO: CASE NAME

RECIPIENT
SIGN HERE

LAST NAME FIRST

FOR AOC CASES: FIRST NAMES OF ALL PERSONS IN CASE.

DD 13123492.0

DPA FORM ADP-469 (REV. 9-15-67)

NOTICE:
THIS CARD IS FOR IDENTIFICATION ONLY
AND SIGNIFIES THAT THE PERSON WHOSE
SIGNATURE APPEARS ON THE FACE OF
THIS CARD IS ELIGIBLE TO:

RECEIVE MEDICAL SERVICES

PARTICIPATE IN USDA FOOD STAMP PLAN

UP TO AND INCLUDING THE DATE OF
EXPIRATION.

HAROLD D. SWANK
Authorized Representative

SEE REVERSE SIDE

FOLD HERE

FOLD HERE

NOTICE TO RECIPIENT

1. SIGN THIS CARD IMMEDIATELY.
2. DESTROY LAST MONTH'S CASE IDENTIFICATION
CARD.
3. NOTIFY YOUR CASEWORKER AT ONCE IF YOU LOSE
THIS CARD.

4. PRESENT THIS CARD WHEN REQUESTING THE
SERVICE(S) AUTHORIZED ON THE FRONT OF
THIS CARD.
5. IF YOU BECOME INELIGIBLE FOR ASSISTANCE
BEFORE THE EXPIRATION DATE OF THIS CARD,
YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR
MEDICAL BILLS.

NOTICE TO MEDICAL VENDOR

1. PRINT CASE IDENTIFICATION NUMBER AND NAME
EXACTLY AS SHOWN WITHIN THE HEAVY BLACK
LINES ON ALL BILLS YOU SUBMIT TO THE
DEPARTMENT OF PUBLIC AID.
2. PHYSICIANS, CLINICS, ETC., PLEASE RECORD
RECIPIENT VISITS BELOW.

PROXY STATEMENT

I AUTHORIZE _____, WHOSE
NAME OF PROXY
SIGNATURE IS BELOW, TO PURCHASE FOOD WITH MY
FOOD STAMPS.

SIGNATURE OF RECIPIENT

SIGNATURE OF PROXY
DATE
PRINTED IN U.S.A. UN 1/AC 1512/6A

DATE OF VISIT

PHYSICIAN'S INITIALS

CID—Case Identification Card

the quality, and the cost of the drug to the physician.”

Question: And prescribed drugs?
Answer: Since a pharmacist fills the prescription, it is he who bills the IDPA for payment of the drug.

Question: At this point, the patient is determined eligible and all identification data are transferred to Form 132. How does the doctor encode the medical procedures performed?
Answer: Let us consider an hypothetical medical situation. An eligible recipient visits a general practitioner’s office to be a patient for the first time. The doctor

examines him and sends his laboratory specimens to a nearby Independent Certified Laboratory for analysis. A few days later the patient goes back to the doctor, this time in a worsened condition and is admitted to the hospital. The GP has a surgeon examine the patient, new lab tests are made in the hospital and x-rays are taken. A gall bladder removal is indicated.
The surgeon, assisted by another surgeon and an anesthesiologist, removes the gall bladder and in the process does an incidental appendectomy. The GP is not involved in the surgical procedure.
The patient progresses well and ten days after surgery leaves the hospital for con-

valescence at home. But during his stay in the hospital, the principal surgeon visited him six times and the general practitioner—his first doctor—called on him twice. After returning home, the patient visited the surgeon twice in his office.

Question: Are you citing an involved medical situation?

Answer: No. There are, of course, many which require less medical care but the case cited is not unusual.

Let us process the procedures administratively in terms of the various doctors and vendors. The first doctor—the GP—may be paid only for the two office visits of the patient made prior to his entering the hospital. The GP's two visits to the hospital, though good public relations, are financially irrelevant as the patient was out of the GP's medical jurisdiction at the time. The GP sends in his Form 132 encoding each visit for services performed—9001-Initial Diagnostic Visit and 9004-Routine Office Visit for subsequent care.

Question: How about the lab tests performed by the Independent Certified Laboratory? The GP initiated them.

Answer: The Lab performed the analyses and, being a certified lab, it, not the GP, bills IDPA direct.

Note that a second series of lab tests were made in the hospital plus x-rays. The hospital is a separate vendor and bills IDPA for these items along with the other associated hospital services.

Question: For what procedures may the principal surgeon charge?

Answer: He is paid for his initial consultation—coded 9028-Consultation. His six visits to the patient in the hospital and the final two visits of the convalescing patient to his office are not chargeable as they are a part of the regular post-operative care normally expected.

The surgeon's principal fee, of course, is for the operation. The procedure was routine and is properly coded 3515-cholecystectomy. Since the appendix removal was performed through the same incision, no additional charge is to be made.

Question: How about the charges of the assistant surgeon and the anesthesiologist? Does the principal surgeon bill extra to reimburse them?

Answer: No. The assistant surgeon bills IDPA direct on Form 132 for his fee. He codes his service as 3515 *but indicates that he was the assistant surgeon, and provides the time involved.*

Anesthesia may be given by an anesthesiologist or a registered nurse anesthetist. If given by a person in private practice he or she bills the IDPA direct citing in this case anesthesia for Code 3515. *The length of time required for the surgery must be shown—as well as materials, if these are supplied by the anesthesiologist and are itemized if a charge is made.*

Question: Are there other helpful hints?

Answer: A simple but important reminder is: Never include on one Form 132 bills for more than one month. A back bill not previously submitted may be forwarded but *use a Form 132 dated for the month the procedure was performed.*

Sometimes a medical procedure is performed which is either not in the CPT or not properly covered. A *full explanation of the procedure* will ensure proper payment based on professional consultation.

Question: Is the Current Procedural Terminology booklet in need of revision?

Answer: In compiling the CPT, AMA's Committee on Insurance and Prepayment Plans greatly advanced the possibility of automating the processing and payment of physician's fees and medical charges in general. Understandably, experience has disclosed that not all medical procedures have been coded and some coded ones do not adequately cover all the alternatives within the generic procedure. To say that certain updatings are needed in no way detracts from the importance of previous encodings. Change is to be expected.

Additional information relating to procedures, policies and payments are to be discussed in the next installment.

"Say that which has to be said in such language that you can stand cross-examination on each word."—Thomas Henry Huxley.



THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Diagnostic Radiology, Cook County Hospital,
and Clinical Professor of Radiology, Chicago Medical School*

This 26 year old white female entered with a complaint of amenorrhea. She had noted unusual hairiness and had been unable to become pregnant in the past five years. Physical examination revealed a questionable enlargement of the ovaries. To further evaluate this a pelvic pneumogram was performed.

What's your diagnosis?

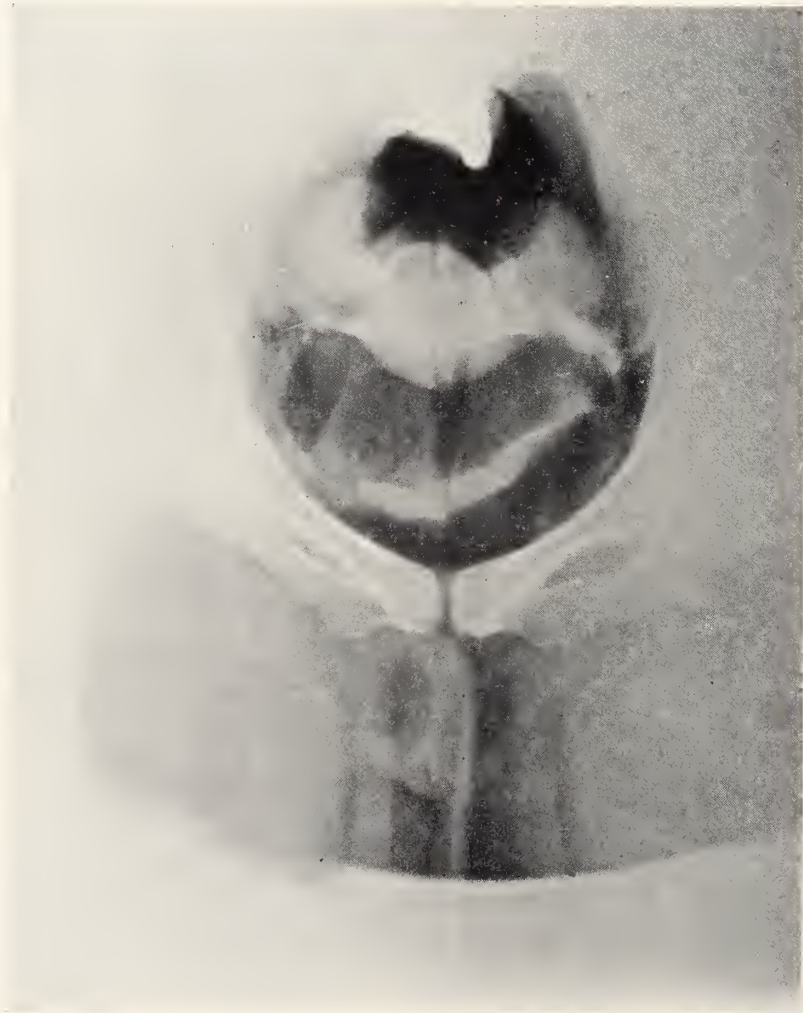


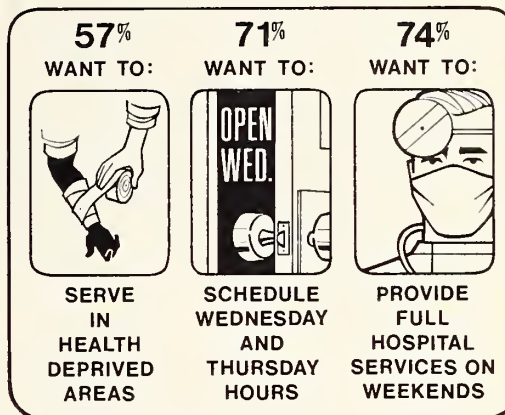
Fig. 1.

(Answer on page 102)

MEMBERSHIP SURVEY RESULTS

ILLINOIS PHYSICIAN SURVEY SHOWS:

**What You Said...
What ISMS Is Doing...**



Part III: Professional Practice Issues

THIS MONTH WE COMPLETE our report on what you *collectively told us* in our August membership survey.

We devote this final installment to the survey questions which are most directly important to you—Professional Practice issues, namely:

- *Full hospital service on weekends
- *Rotated Wednesday-Thursday schedules
- *Service in health-deprived areas
- *Action against hospital service costs
- *Stricter control of hospital hiring of MD's
- *Fuller responsibility for nurses in acute cardiac care units
- *A complete working relationship with osteopaths.

On these issues we give you the results of the membership survey . . . background information . . . and the action that the ISMS leadership is taking in response to your opinion.

We similarly treated Legislative and Legal topics in the November IMJ, and Socio-Economic in the December issue.

While elated by the responses from some 3,000 members, we realize that any survey—no matter how carefully prepared or well received—has certain limitations.

We are aware that on such complex topics, our questions—and your checkmarks—could not always convey the full message.

So in reporting on the survey, we have selected those questions and responses which lend themselves to the clearest, most forceful evaluation.

Of course, your answers to every portion of the survey have been invaluable in advising your ISMS leadership of your wants.

Your opinions have given ISMS a keener sense of direction . . . they have stirred the breezes and currents.

And as these articles point out, your leaders are sailing forward.

Matthew B. Eisele, M.D.

Matthew B. Eisele, M.D.
Chairman, Committee on Public Relations

FULL HOSPITAL SERVICE ON WEEKENDS?

QUESTION AND GENERAL RESPONSE:

Patients frequently enter hospitals on weekends, without being able to receive medical attention until Monday. Some observers propose that hospitals be put to full-time week-end and holiday use, including elective surgery and routine diagnosis. **If such a schedule were feasible in your area, would you be willing to participate in it?**

MD's in
FAVOR:
74%

BREAKDOWN:

The only marked differences were in these two categories:

By area:	
Chicago Medical Society	77%
Downstate	71%
By Type of Practice:	
Solo practice	75%
Partnership or Group	75%
Hospital-based	65%

BACKGROUND:

Bed and laboratory usage in hospitals now follows "a feast and famine pattern," Dr. Frederick Stenn, Chicago internist, wrote last July in the *"Illinois Medical Journal:"* "a bottleneck on Sunday night, a deluge on Monday, a rush on Tuesday, a steady flow on Wednesday and Thursday, a slackening on Friday, a trickle on Saturday morning, and a dead-stop on Saturday afternoon and all day Sunday. The fluctuation is seen most with surgical patients . . ."

Hospitals used to give complete care seven days a week. They switched to five and 5½ days primarily because of the expanded need and cost of paramedical personnel.

This factor—and "a natural reluctance to give up comfortable ways"—are two reasons why most hospitals stick to the shortened schedule, says an article in *Medical Economics*. Also, there is a conviction "that only very large hospitals can extend use of facilities without raising expenses above income."

However, resumption of the 7-day system at three hospitals in the East and Michigan has raised their income and lowered their capital investments, in addition to sparing the patient from delay and extra expense, the article noted. These hospitals range from 400 to 708 beds.

At one of these—Albany (N.Y.) Medical Center Hospital—the 7-day week generally reduced the average length of patient stay by half a day. "Maybe a half-day average doesn't sound impressive," said its medical director, "but it meant we could care for 981 more patients in a year."

However, he commented, "The larger the hospital, the easier the change." Some observers believe the obstacles could be particularly big in sparsely populated areas with personnel shortages.

ACTION TO BE TAKEN:

The ISMS Board of Trustees has referred the question and survey response to the Council on Medical Service for study and recommendations. Dr. Philip G. Thomsen, on his President's Tour, has invited county medical societies to discuss the proposal with hospitals in their areas.

ROTATED WEDNESDAY - THURSDAY SCHEDULES?

QUESTION AND GENERAL RESPONSE:

Growing health-care needs and the physician shortage have raised questions about unavailability of doctors on Wednesdays or Thursdays. **Would you be willing to participate in rotated schedules for these days in your area?**

MD's in
FAVOR:
71%

BREAKDOWN:

The most significant differences appeared in these categories:

By area:

Chicago Medical Society
Downstate

64%
78%

By Type of Practice:

Solo practice
Partnership or Group
Hospital-based

68%
74%
79%

Younger physicians favored the step by wider margins than older doctors.

BACKGROUND:

The midweek off-day—mainly Wednesday in Chicago and Thursday downstate—reflects the general drop in the physician's once-endless schedule.

In 1967 America's MD's were giving a median of 48 hours a week to patient care. A recent survey by *Medical Economics* gave this breakdown:

8%	of physicians	less than 5 days of practice a week
25%		5 days
22%		5-1/2 days
18%		6 days
7%		6-1/2 days
20%		7 days

While a number of physicians already are working Wednesdays and Thursdays, some observers feel systematized schedules are necessary to assure the level of service. Such schedules, they say, would not only alleviate patient frustration but: (1) lessen the widespread overuse of hospital emergency rooms on those days; (2) give better balance to the physician's work week; and (3) enhance the medical image at a time of growing health-care demands and physician shortages.

ACTION TO BE TAKEN:

The ISMS Board of Trustees referred the question and survey results to the Committee on Public Relations. Dr. Philip G. Thomsen, on his statewide President's Tour, has suggested to county medical societies that they consider implementing the off-day schedule idea.

SERVICE IN HEALTH-DEPRIVED AREAS?

QUESTION AND GENERAL RESPONSE:

Inability to hold or attract permanent physicians has contributed to the health-care problem in deprived areas. If you live near such an area, **would you be willing to volunteer a certain number of hours each month to clinical or individual health care there?**

MD's in
FAVOR:
57%

BREAKDOWN:

About 90 per cent of the survey respondents answered this question—suggesting that most DO live near an area which they regard as care-deprived.

The divisions were as follows:

By area:

Chicago Medical Society	55%
Downstate	60%

By age:

Under 40	62%
40 - 55	61%
Over 55	49%

By Field of Practice

General practice	54%
Specialty	59%

By Type of Practice

Solo practice	55%
Partnership or Group	57%
Hospital-based	73%

BACKGROUND:

The shortage of physicians in rural areas and in "inner cities" has reached a critical stage.

"A declining rate of new G.P.s and an aging group of physicians in rural areas add up to a rapidly increasing crisis in rural health care unless a solution is found soon," a North Carolina clinical director wrote in *Medical Economics*.

In the 31 southernmost counties of Illinois, there is only one M.D. per 1,450 people, with extreme scarcities in the

more rural counties. The fall-off in urban slum areas has been just as sharp. In Chicago's Woodlawn "ghetto," for example, the number of doctors has shrunk from 122 in 1930 to 44—although the population has swollen to 77,200.

Generally, an estimated one in ten Illinoisans lacks a regular physician.

Perhaps no permanent solution can be found until medical demand and supply are equalized. As a temporary relief, some physicians already are making periodic visits to deprived areas. It was felt that more might wish to volunteer their services—working perhaps in local centers that could be established with government, community or private funds.

ACTION TO BE TAKEN:

The ISMS Board of Trustees referred the matter and the survey response to the Council on Legislation and Public Affairs, since coordination at the community level would be required.

On his ISMS President's Tour, Dr. Philip G. Thomsen has invited larger county medical societies to set up "formal programs of voluntary assistance" to neighboring deprived areas, which would provide the necessary facilities.

ACTION AGAINST HOSPITAL SERVICE COSTS?

QUESTION AND GENERAL RESPONSE:

Do you favor any one or more of these approaches as a way to reduce hospital service costs?

MD's in
FAVOR:

- | | |
|---|------------|
| a. Increasing the authority of Utilization Review committees to eliminate unnecessary hospitalization? | 69% |
| b. Areawide consolidation of purchasing, laundry, etc.? | 81% |
| c. Mandatory areawide planning for capital expansion and specialized needs? | 69% |

BREAKDOWN:

Older physicians generally favored the three steps by wider margins than younger doctors.

By area, the division was as follows:

	GREATER U. R. AUTHORITY	GROUP PURCHASING	MANDATORY AREAWIDE PLANNING
Chicago Medical Society	74%	84%	71%
Downstate	64%	77%	65%

Hospital-based physicians differed markedly from other doctors on only one step—greater authority for Utilization Review committees, as follows:

	MD's in FAVOR:
Solo practice	65%
Partnership or Group	73%
Hospital-based	82%

BACKGROUND:

Health-care prices rose 66.6% in America from 1950 to 1965—largely because of the 165.2% surge in daily hospital service charges. In calendar 1967 the health-cost increase was 7%—including 19.1% for hospital service.

To curb hospital costs as well as overcrowding, AMA recognized the principle of Utilization Review in 1960. The Medicare Act of 1965 required UR committees in all participating hospitals and extended-care facilities. The committees, as envisioned by that act, serve two functions. One is educational, in the area of admission-practices, duration of stays and professional services. The other is applicatory, and calls for review of long-stay Medicare cases.

The ISMS House of Delegates has taken the position that UR committees "are to be composed only of physicians and to serve only *an internal function* . . . they are not obligated to serve as investigative bodies for any non-physician outside the hospital."

Some observers believe UR committees could be more effective, without abandoning ISMS insistence on internal direction. They suggest that the committees devise strict guidelines on duration of stays. They also suggest more preventive as well as follow-up action against overstay.

Individually and in groups, hospitals are resorting to several devices to cut costs.

Many hospitals across the country—including the Chicago area—have adopted group purchasing of supplies and equipment. Chicago hospitals also are studying the feasibility of centralized laundry and linen service—a step which has saved seven Los Angeles hospitals a total of more than \$300,000 a year.

Some physicians believe areawide planning councils—organized by MD's, hospitals and community leaders, and armed with enough authority to be effective—could: (1) coordinate development and stem needless duplication in hospital services, facilities and construction; (2) counteract the threat of federal control in this kind of planning.

ACTION TO BE TAKEN:

The ISMS Board of Trustees referred the survey response to the Council on Medical Service. The Committee on Hospital Relations, incidentally, is planning a study on the expense and overuse of hospital emergency rooms.

STRICTER CONTROL OF HOSPITAL M.D. HIRING?

QUESTION AND GENERAL RESPONSE:

A Chicago hospital lost its license last winter over an infant-death case involving an unlicensed staff doctor. **Should ISMS urge the Illinois Department of Registration and Education to require hospitals to submit M.D. employment applications to IDRE for a license check prior to hiring?**

MD's in
FAVOR:
83%

BREAKDOWN:

The only appreciable difference appeared in the Type of Practice breakdown, as follows:

Solo Practice	84%
Partnership or Group	82%
Hospital-based	74%

BACKGROUND:

The hospital lost its license after allegedly turning away an obstetric patient whose baby subsequently died. Last November, however, County Circuit Court set aside the license revocation.

Investigators said the "house physician" in the case, though posing as a graduate of a Mexico City medical school, had left without graduating... that he consistently failed the certification examination given by the Educational Council for Foreign Medical Graduates.

The Illinois Department of Registration and Education noted in a statement last year:

"The enforcement of the Medical Practice Act with respect to the elimination of unlicensed persons practicing medicine in a hospital is **dependent upon cooperation by responsible persons within the hospital**. It should be noted that lack of cooperation or failure to meet responsibilities can in a proper case be translated into criminal liability and disciplinary action..."

The ISMS survey question was based on a belief that a gap in responsibility now exists. A mandatory IDRE check of M.D. employment applications conceivably would close this gap... and spare hospitals from risk and possible criminal action.

The scope of the problem is nationwide. Recently the American Hospital Association advised its member facilities to let the AMA screen their M.D. employment applications.

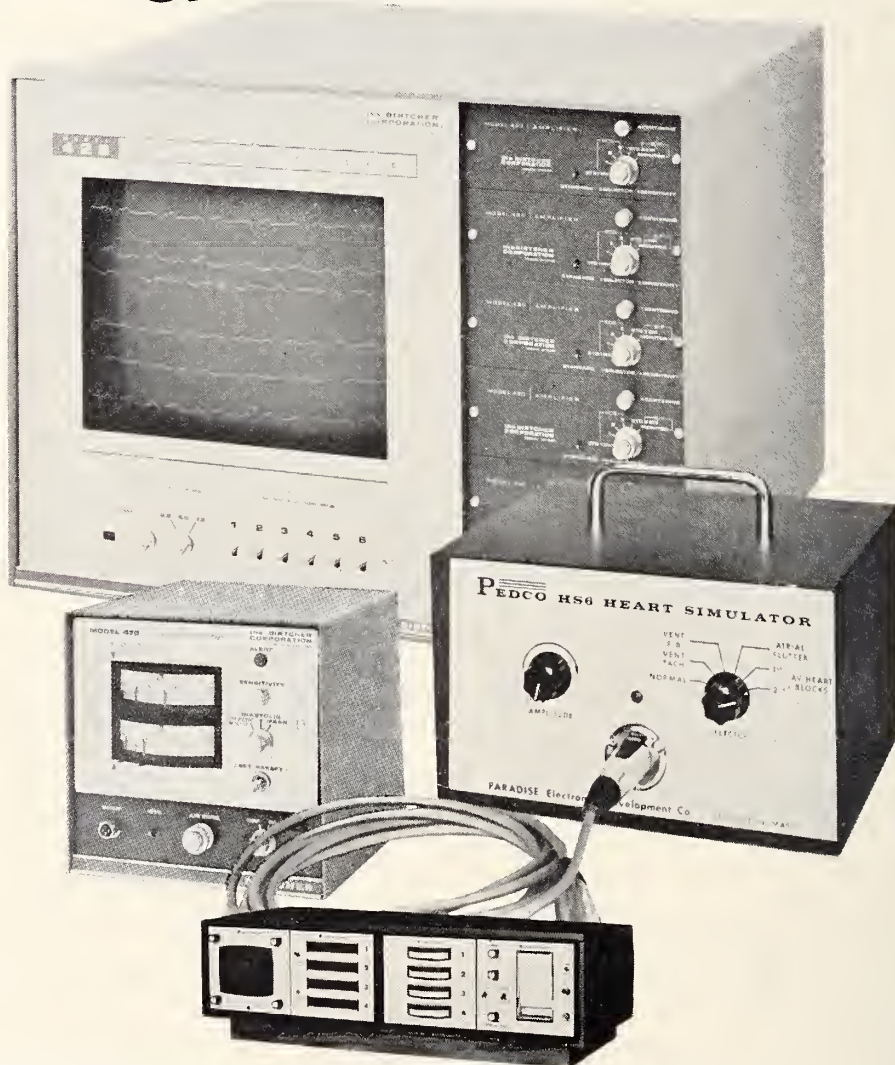
ACTION TO BE TAKEN:

The ISMS Board of Trustees referred the survey response to the Committee on Medical Practice and Quackery, which already had been studying the general problems.

FULLER NURSE ROLL IN ACUTE CARDIAC CARE?

Should ISMS support the Illinois Nurses' Association and help develop guidelines in giving larger responsibility in acute cardiac care units when no physician is immediately available?

89% say yes



QUESTION AND GENERAL RESPONSE:

The Illinois Nurses' Association wants RN's to be given fuller responsibility in acute cardiac care units when no physician is immediately available. This would include monitoring, defibrillation and use of resuscitative equipment. **Should ISMS support the INA proposal and help develop guidelines?**

MD's in
FAVOR:
89%

BREAKDOWN:

Results were almost identical in each membership category.

BACKGROUND:

As health care becomes more burdensome and complex, the responsibilities of paramedical personnel must be defined.

Cardiac resuscitation by nurses, particularly, has brought a widespread demand for policies and guidelines. The AMA late in 1967 adopted a statement recognizing—with certain qualifications—the propriety of registered nurses using monitoring, defibrillation and other equipment and instituting lifesaving measures when a licensed M.D. is not immediately available.

The Illinois Nurses' Association early last year presented ISMS with a proposed statement on RN responsibility in acute cardiac care units. The ISMS Board of Trustees—after debating the proposal—called for further consideration.

ACTION TO BE TAKEN:

The survey results have an influence in ISMS deliberation and progress on the proposal. In trying to iron out technical and legal details, the ISMS Committee on Nursing has been conferring with representatives of INA, the Illinois Hospital Association and the Illinois and Chicago Heart Associations. The committee may make a final recommendation at the January meeting of the ISMS trustees.

FULL WORKING RELATIONSHIP WITH OSTEOPATHS?

QUESTION AND GENERAL RESPONSE:

Should ISMS pursue steps to allow full amalgamation of osteopathy with medicine, including medical training?

MD's in
FAVOR:
58%

BREAKDOWN:

Differences of outlook appeared in three membership categories, as follows:

By area

Chicago Medical Society
Downstate

56%
61%

By Field of Practice:

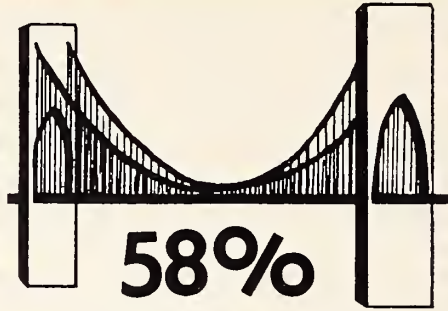
General Practice
Specialty

53%
61%

Should ISMS pursue steps to allow full amalgamation of osteopathy with medicine, including medical training?



MD



DO

By Type of Practice:

Solo Practice

54%

Partnership or Group

64%

Hospital-based

67%

BACKGROUND:

The traditional gulf between Illinois MD's and osteopaths was partially bridged in May, 1968, when the ISMS House of Delegates adopted this recommendation:

"Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois."

Advancement of the working relationship could include: (1) more joint staffing of hospitals and (2) more joint training at the postgraduate level in teaching hospitals.

Joint staffing of hospitals has progressed further in various neighboring states, where there are more DO's.

In California, some years ago, MD's and DO's merged; in 1962 the AMA and the Association of American Medical Colleges accredited the California College of Medicine, former osteopathic institution. Those developments stimulated cooperation, at least, in other states.

In Michigan, State Medical Society delegates voted in 1967 to admit qualified osteopaths to associate membership. To relieve the health-manpower shortage, the society's council recently urged Michigan medical schools to prepare to train osteopaths as well as medical physicians.

The AMA House of Delegates in December approved—by a vote of 162 to 97—a proposal to permit county and state medical societies to accept osteopaths as active members. On the other hand, the American Osteopathic Association's House of Delegates has threatened "discipline up to and including expulsion" of any member joining an AMA affiliate.

ACTION TO BE TAKEN:

The ISMS Board of Trustees referred the survey response to the Committee to Study Osteopathic Problems.



ILLINOIS ASSOCIATION OF THE PROFESSIONS

IAP PROGRAM

The Illinois Association of the Professions is a non-profit corporation, incorporated under the laws of Illinois on February 6, 1954. Thirteen other states have organized similar associations and an American Association of the Professions has been incorporated.

The IAP was created to provide the organizational machinery to utilize the combined strength and counsel of all the professions for the advancement of professional ideals and professional welfare.

One of the most significant results of this combined effort was the establishment of a separate registration of the professions in the Department of R & E.

In view of the many government and other programs that have been initiated in state and local areas, it behooves the professions to resist the trends toward socialization of the professions, and prepare to protect the future of the free enterprise or individual practice system. A few examples of such programs include:

1. O.E.O.
 - Free pharmacy clinics
 - This could be expanded to Dentistry and Medicine
2. Union Clinics
 - Employed professionals
 - Unionization of Professions
 - Contract with industrial clinics
 - Non-professional ownership
 - (Franchise groups, chains, etc.)
 - Professional services such as medical, legal, accounting, etc.
3. Corporate Practice of Medicine
 - Ownership by non-professionals
 - (Franchise group, chains, convalescent homes)

Unless the professional societies unite in a combined effort to protect the future of private practice, we may soon find our-

The best substitute for experience is being 17 years old.—Gas House Gazette.

selves employed in our own professions.

Private practice serves the best interests of the public, and it would be well for us to utilize the combined efforts of our 43,000 professional people in Illinois to protect this interest.

We ask the professional societies for their support, so that IAP may fulfill the ideals and goals on which it was founded.

New Dean at Urbana College of Veterinary

Dr. L. Meyer Jones was named Dean of the College of Veterinary Medicine at Urbana effective September 1, 1968. Dr. Jones is presently Dean at the School of Veterinary Medicine at the University of Georgia. He is a native of Hartford City, Indiana, and received an AB in 1935 from DePauw University; DVM and MS in 1939 from Iowa State University and Ph.D. in 1945 from the University of Minnesota Medical School. He was a member of the Iowa State faculty from 1935-39; vice president of scientific affairs, Standard Chemical Co., Omaha, Nebraska, 1961 and Director of Scientific Activities, American Veterinary Medical Assoc. 1960; 1962-1966. Dr. Jones' appointment fills the vacancy created by the retirement of Dean Carl A. Brandly, August 31.

Registration Certificates

The possibility of the Illinois Department of Registration and Education awarding registration certificates to professional engineers at regional meetings has been suggested.

Holding registration examinations in some downstate locations, in addition to Chicago, is also under consideration.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

IDPA Seeks Review Setup in All County Societies

The Illinois Department of Public Aid is appealing to county medical societies to report names and addresses of their review committee members—or set up such committees if they have none. Functions of the committees include better liaison between the state agency and local physicians, review of MDs' complaints and fee appeals before they reach the ISMS level, and development of utilization review procedures as required under Medicaid (public aid). Early in December, 42 county societies had review committees—formation of which had been urged by the ISMS House of Delegates in May. In counties having very few physicians, liaison may be achieved through a neighboring county society or the ISMS district trustee, an IDPA official suggested.

ISMS Malpractice Program Attracts All Ages, Skills

The ISMS-sponsored Professional Liability (Malpractice) Insurance Program is growing "favorably" among all types of practicing members, Parker, Aleshire & Company, the administrator, reported. Almost three per cent of the policy holders are more than 80 years old, while 10 per cent are more than 70. Among the five coverage categories, 14 per cent are in Class V (specialists such as neurosurgeons, plastic surgeons, orthopedists, anesthesiologists and gynecologists) while 33 per cent are in Class IV (performers of major surgery on their own patients). These figures substantiate the promise to extend coverage regardless of age or specialty, company officials told the ISMS Committee on Medical Economics and Insurance. About 60 per cent of the policy holders are members of Chicago Medical Society.

1967-68 Med School Openings Higher in U.S. and Illinois

U.S. medical schools had a record-breaking 18,274 applicants in 1967-68 and were able to enroll 9,314—an increase of 539 over the previous year's accommodations. Of the additional openings, 114 were in new schools and 425 in previously existing schools, according to the Association of American Medical Colleges. In Illinois' five schools, the 604 first-year enrollments of 1967-68 were 29 higher than the year before,—but no further gain is estimated for 1968-69.

Three Chicago Workshops Set on Government Health Programs

The ISMS series of Workshops on Government Health Programs—aimed at making physicians and medical assistants more adroit in claims procedures—will be carried into Chicago this winter. Welfare agency and insurance representatives will explain—and answer questions on—Medicaid (public aid), Medicare, General Assistance, CHAMPUS and other programs. The Workshops will be Wednesday, January 22, at the Sherman House, Clark and Randolph; Thursday, January 30, at the Shoreland Hotel, 5454 South Shore Drive, and Wednesday, February 5, at St. Mary of Nazareth Hospital's nursing gym, 1127 N. Oakley (Haddon Street entrance). Each will run from 1 to 5 p.m. Invitations were mailed to all Cook County physicians. A total of 1,000 doctors and assistants have attended in Belleville, Carbondale, Joliet, Alton, Moline and Rockford.

AMA Backs Illinois Proposal for More Doctors in RMP

The AMA House of Delegates last month in Miami Beach adopted an Illinois resolution calling for a greater MD voice in the Regional Medical Program's National Advisory Committee. The Secretary of Health, Education and Welfare would be asked to "amplify" the committee with physicians suggested by the AMA Board of Trustees. Noting that RMP is concerned with "heart disease, cancer, stroke and related diseases," the resolution requests the HEW secretary to define "related diseases."

HEW Staff Team Will Survey IDPA Utilization Review

A team from the Department of Health, Education and Welfare staff will arrive January 20 for a survey of Illinois Department of Public Aid progress in utilization review under Medicaid. It will check on steps taken to prevent overutilization of services, excessive stays in hospitals and nursing homes, and overpayments of fees. The cross-country surveys will help HEW make recommendations to the new Congress on Medicaid practices, said Dr. Henry A. Holle, IDPA medical director. "We think we're reasonably diligent," he told the ISMS Advisory Committee to IDPA.

Administrative Costs 9.5% in Medical Part of Medicare

Administrative expenses of the medical-insurance portion of Medicare totaled \$143,000,000 across the U.S. from July, 1967, to June, 1968, or an estimated 9.5 per cent of benefit payments. This was the same percentage as in the previous fiscal year. The figures included expenses of carriers as well as those incurred directly by the Social Security Administration and other government units, SSA said. The 50 carriers processed about 46,315,000 bills from physicians and suppliers in 1967-68. Administrative costs of Medicare's hospital-insurance program came to \$79,000,000 that year, or about 2.1 per cent of the \$3,700,000,000 in benefits paid.

—By DON B. FREEMAN

Addenda to Reference Issue

The following items are presented to enable the modification of information contained in the Annual Reference Issue of the Illinois Medical Journal published October, 1968. Each item is keyed to the appropriate page in the October issue.

page 400

Change date of **Policy Manual**

From: May 1967

To: May 1968

page 407

Ex-Officio Members Without Right To Vote
(Past Trustees)

Delete: Charles O. Lane, West Frankfort, Councilor from the 9th District

Past Presidents

Add: Caesar Portes1967

page 408

Chicago Medical Society Delegates and Alternates

North Shore Branch

Add: H. Kenneth Scatliff as Alternate for Chester L. Crean

page 415

Sangamon County

Add: EXECUTIVE SECRETARY L. R. Brosi, 2100 Lindsay Road, Springfield, 62704

Will-Grundy County

Add: EXECUTIVE DIRECTOR Don M. Kline, 305 N. Ottawa Street, Joliet, 60435

page 420

On Organization Chart

under Medical Legal Council

Change: Licensure and Quackery to Medical Practice and Quackery

page 422

Council on Medical Education

Add: CONSULTANT William M. Lees, M.D., 6518 N. Nokomis, Lincolnwood 60646

page 431

Committee on Maternal Welfare

Delete: name of George E. Fagan (no replacement named)

page 436

Advisory Committee To Paramedical Groups

Add: Dr. Carl Clark will serve as a consultant to the Committee and be the official ISMS representative to the Illinois Medical Assistants Association-IMAA will elect its own Advisory Committee following the national pattern.

Dr. James Hartney and Dr. Allison Burdick, Jr., will represent ISMS on the HCCI Board.

Dr. Casper Epstein will be the ISMS delegate and Dr. Carl Clark alternate delegate to the HCCI Senate.

page 464

Narcotics Advisory Council

Delete: Repr. John Merlo, Chicago

Add: Repr. Calvin L. Smith, Chicago, George M. Stabler, M.D.

Change: Joseph S. Skom, M.D.

To: Joseph H. Skom, M.D.

page 479

Poison Control Centers—Chicago

Add: Presbyterian-St. Luke's Hospital, (Master Chicago Control Center) 1753 West Congress Street 738-4411, ext. 2267

page 516

Note: Under **Artificial Kidney Centers** Subheading "Presently available for acute poisoning cases only" applies *only* to Riverside Hospital—Kankakee and to no other center.

Add:

St. Francis Hospital, 825

Good Hope St., Cape

Girardeau, Mo.

Phone: 334-4461 Person in charge: Sister M. Venard Location: Surgery

Barnes Hospital, Barnes

Hospital Plaza, St. Louis

Mo.

Phone: 367-6400 In charge: Neal Bricker, M.D. Location: Second Floor

Note: All listed centers have also been approved for chronic hemodialysis except the following:

Edgewater Hospital, Chicago

St. Joseph Hospital, Elgin

Riverside Hospital, Kankakee

Swedish-American Hospital, Rockford

St. John's Hospital, Springfield

St. Francis Hospital, Cape Girardeau, Mo.

page 520

Approved Schools of Cytotechnology

Delete: Evergreen Park—Little Company of Mary Hospital

page 521

Schools of Medical Technology

Add: Belleville—St. Elizabeth Hospital; Evergreen Park—Little Company of Mary Hospital

page 526

Medical Examining Board

Add: George G. Jackson, M.D., Chicago; William G. McCarthy, M.D., Dolton

page 531

Rule VIII, sections 10 and 11; Eliminate section 10 as printed, no longer applicable; renumber section 11 as section 10.

Placental Extract Effective in Arthritis

BY EUGENE F. TRAUT, M.D./CHICAGO

The decreased incidence and remissions of some diseases, especially rheumatoid arthritis, during pregnancy¹, has led to attempts to reproduce this favorable effect by therapeutic trials of preparations of placenta.²⁻⁶ More recently benefit in rheumatoid arthritis has been claimed and refuted following the injection of corpus luteum and progesterone with estrogen.⁷⁻⁹ Remissions of disease have been ascribed to the rise in corticosteroids during pregnancy.¹⁰

The blood serum of pregnant women has been said to benefit patients with rheumatoid arthritis.¹¹⁻¹⁵

Placental extracts remarkably controlled formaldehyde arthritis in rats.¹⁶

Many physiologically active substances, ordinarily produced by the ovary, adrenals or the pituitary have been isolated from placenta.¹⁷⁻³⁰



Eugene F. Traut, M.D. is Director of the Arthritis Clinic, Cook County Hospital. He received his M.D. from Rush Medical College and did his internship at Presbyterian and Cook County Hospitals. He is the author of *Rheumatic Diseases*. Dr. Traut gratefully acknowledges the assistance

of A. Dubin, Chief of Biochemistry, Hektoen Institute, in the preparation of this paper.

Investigators have made preparations from placentas secured during the second and third trimesters and at delivery. In the first trimester the placenta lacks estrogen. Animal as well as human placentas have been utilized. Fresh placenta has been used. The harvest of active principals was thought to be greater in placentas frozen for a period. Assuming an affinity of the active principals for the maternal globulins it has seemed preferable to make extracts from the cold placenta. The "cold" method of extraction is best suited to avoid destruction of labile biologic extractives. Filatov in 1933 boiled the placenta to make the extract in order to reduce the content of protein and thermolabile "biogenic stimulators." Boiling does not inactivate adrenocorticotropin.

Beneficial effects of pregnancy in arthritis usually persists for several weeks after delivery. Improvement following injections of plasma obtained postpartum is said to have come gradually and only slowly receded. Extracts of muscle have been used as controls for placental extract injections.³¹

Method of Study

Placentas were extracted by a method calculated to retain the greatest quantity of active principals. The extract was used under an informative method of control adapted for use by six rheumatologists treating a large group of adult patients

presenting a wide spectrum of "rheumatic" diseases.³²⁻³⁴ Our patients, representing the poor of a large city, are referred to the arthritis clinic only after a screening maximally effective in selecting only those obviously organically ill. Accustomed to hardship, they are not very introspective nor do they report minimal changes in their symptoms. Most are women. About one-half of them are Negro.

A complete medical history and physical examination are a part of the patient's first visit. Laboratory procedures, including X-ray studies, are scheduled. All patients are then directed to take a tablet containing 0.3 Gm. of lactose after each meal and at bedtime. At subsequent visits they are instructed to continue the tablets if substantial improvement is reported and observed.

When and if improvement from the tablets does not occur, 1 ml. of normal saline solution is injected into the buttock. Continuance of the saline solution terminates with a report or observation of no further improvement. Placebo procedures thus are terminated on worsening or failure to show positive, progressive improvement.

At this point the effect upon the patient's illness of another therapeutic procedure is studied. Thus, placental extract is administered only to patients determined to be placebo-resistant. Multiple, simultaneously used treatments are avoided. As stated in previous studies, many of our patients have taken for years and continue to take aspirin, proprietaries containing salicylates and wear amulets.

Procedure

Human placentas are finely ground and extracted within one-half hour of delivery. This method has given a more potent extract than preparing the extract after freezing the placenta. By employing cold normal saline solution we do not extract adrenocorticotropin nor adrenocortico-steroids, these hormones being precipitated and filtered out. Tests in mice demonstrate a strong chronic gonadotropin effect but no ACTH effect. The beneficial effect of the extract was not enhanced by using placentas obtained by cesarean section.

The material employed was a brownish emulsion contained in a rubber-capped vial. After trying dilutions we finally used the undiluted material. Treatment was started with 0.1 ml. injected through a 22

gauge needle into the muscle of the buttock. The dose was increased by 0.1 ml. at each weekly visit. Patients experiencing relief lasting less than one week were injected every third day. Depending upon the patient's symptoms and physician's observations the dose was increased, decreased, kept the same or omitted.

Considering the possibility of explaining the beneficial effect in arthropathies via the known antibody content of the globulin in placental extract,²¹⁻³⁵ hyperimmune globulin was injected weekly into nine patients with no observable effect.

Results

We have studied the effect of our placental extract on 77 patients for five years. The kinds of rheumatic disease treated are shown in the table.

Thirty-four patients with degenerative arthritis and 27 patients with rheumatoid arthritis of all grades of severity were clinically improved after the first dose (0.1 ml. of the undiluted extract). Many of the patients with degenerative arthritis had manifestations acute enough (acute synovitis) to elevate the sedimentation rate above 20 mm. Of the 27 patients with rheumatoid arthritis 24 were conspicuously benefited. Three patients with chronic gouty arthritis had decreased swelling, stiffness and pain after each weekly injection.

Two patients with chronic infectious arthritis of undetermined etiology responded to the placental extract with less pain and swelling. A patient with chronic recurrent, unclassified arthritis was benefited as was a patient with chronic subdeltoid bursitis and one with subacute shoulder-hand syndrome.

Most reported improvement within 2 to 12 hours after being injected. Improvement usually lasted three to five days, decreasing gradually thereafter. Some reported continued but lessened relief for two weeks after the injection. After three to five injections the "rheumatic" complaints and findings have, in many, decreased to a new level of comfort not experienced since the onset of the joint disease.

The improvement in the clinical condition of patients receiving placental extract was in sharp contrast to their previous condition and also was markedly better than that of the hundreds of other patients receiving conventional therapy (salicylates

Placental Extract in Treatment

Diagnosis	Patients treated	Benefited	Not benefited
Degenerative arthritis	42	34	8
Rheumatoid arthritis	27	24	3
Infectious arthritis	2	2	
Periarthritis of shoulder	3	3	

with indomethacin or phenylbutazone).

In addition to the pre-extract placebo control we occasionally interrupted the placental injections by injecting normal saline solution at one or several of the patient's visits. Patients were at no time informed of the composition of injected material. The reports of increased strength and lessened pain after placental injections were usually lacking after the substitution of saline solution for the injections of placenta.

In some patients a continuing remission was brought about. These patients maintained a satisfactory symptomless state on weekly injections of saline or discontinuance of all treatment. They have remained in a remission for months or, in a few instances, for years. Discontinuing placental extract let to relapse in most patients. The resurgence of symptoms and signs usually appeared gradually within days to weeks. These patients taking salicylates or steroids, have been observed to follow the usual course of other patients in the years subsequent to the placental injections. They return wistfully inquiring when "the medicine" will be resumed.

Of the eight patients with rheumatoid arthritis failing to benefit from placental extract one received only one injection. In three patients one of the injections caused chills and fever without any local reaction at the injection site. These systemic manifestations disappeared in 12 hours. Two patients developed swelling and redness at the injection site following the first injection. Other local reactions were encountered with large doses of the extract. The reactions ceased with the lowering of the dose. One patient demonstrated the findings of diabetes mellitus while receiving the extract. The diabetes became subclinical

on discontinuing the injections. Patients with established diabetes mellitus preceding the placental injections have not required any change in insulin dosage while receiving placental injections. A patient with perennial bronchial asthma had no asthmatic symptoms while receiving the extract.

Nine patients with degenerative arthritis failed, as judged by placebo controls, to benefit from placental extract.

Summary

Recently delivered placentas yield an aqueous extract capable of frequently and markedly ameliorating the symptoms and findings of some common types of joint disease.

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Crisis in Health Prices

"We cannot meet present and future medical care needs where dire shortages of facilities and trained personnel already exist by hiding behind the thickness of the national budget. Inadequate colleges and insufficient student enrollments today mean shortages of doctors, nurses and other health professionals tomorrow, just as postponement of essential hospital modernization and construction results in still more shortages and more expensive facilities in the future. Should the increased expenditures necessary to safeguard the nation's health—and the health of your family and mine—require additional taxation and cutbacks in other, less essential categories, then we must go ahead with it and tax ourselves appropriately. And the private sector realizes the opportunity to participate in what is potentially the greatest investment in tomorrow—support of higher education—through an invigorated program of private and corporate giving in the order of magnitude of \$1 billion a year by 1974." "The Lent Report states that the 'single most important health problem in New York State and the nation is how to increase the number of professional registered nurses.' Or, as Surgeon General William Stewart put it so succinctly: 'Our nurses are undermanned. Yet, nurses receive on the average a little over \$5,200 annually which compares unfavorably with the average factory worker's average wage of \$5,975 a year. It has been said of the nurse that 'she must feel like a girl, act like a lady, think like a man, and work like a dog.' Let us add to that—and be paid like a member of an honored and skilled profession'."

In the complex picture
of moderate to severe anxiety...



there is a **new** reason
for prescribing **Mellaril**
(Thioridazine HCl)

**effectiveness in
mixed anxiety-depression**

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril[®]
(Thioridazine HCl)
25 mg. t.i.d.

**for moderate to severe anxiety
and mixed anxiety-depression**



Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the Journal is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

LASALLE COUNTY: Tonica; population: 850. Trade area, 3,000. Only physician retired recently. Nearest physicians, 5, 10 and 18 miles. Nearest hospitals at Streator, LaSalle, and Peru, 18, 10 and 11 miles; Peoria, 65 miles. New office building of retiring physician available; equipment available if desired. Agricultural area. Methodist Church. Grade and high schools. Adequate recreational facilities available in nearby LaSalle and Peru. For further information contact:

M. Miller, Mayor, Tonica

Mr. Ernest G. Pooter

Edgar L. Webb, Business Men's Association, Tonica

LAWRENCE COUNTY: Bridgeport; population: 2,500. Trade area, 18,500. One physician; 1 died in 1966, needs replacement. Seventy-four bed hospital at Lawrenceville, 5 miles; 14 miles to Vincennes, Ind. Two drug stores. Sources of income: oil and agriculture. Churches: Seven Protestant and Catholic. Grade and high schools. Golf courses, pools, bowling. Modern medical building completed as suggested by Sears Foundation. For further information and copy of Sears survey contact: Mayor Russell Boatman, 369 Church St., Bridgeport. Phone 618-945-7140; or Mrs. Loren W. Ellison, Bridgeport.

LAWRENCE COUNTY: Lawrenceville; population: 6,800. Trade area, 35,000. Several small towns in area without physicians. Six doctors—ages 66, 60, 46, 47, 40, and 37. Lawrence County Memorial Hospital 74 beds; 70 miles from Evansville, population 125,000. Three drug prescription stores. Office space available, financial assistance can be arranged. Mining and agricultural community. Churches: Protestant and Catholic. Grade and high schools. Vincennes University, 9 miles. Country Club has golf course and swimming pool. For further information contact: C. G. Stoll, M.D. and Tom Kirkwood, M.D., Lawrenceville.

LAWRENCE COUNTY: St. Francisville; population: 1,040. Trade area, 2,500. Last physician died in 1962. Nearest doctors at Vincennes, Ind., Lawrenceville and Mt. Carmel, 12, 17 and 21 miles. Nearest hospital at Lawrenceville, 12 miles. Evansville, Ind. 63 miles. Financial assistance can be arranged. Churches: Catholic and Protestant. Grade and high schools. Nearest golf course and swimming pool, 2 miles. For further information contact:

Mr. W. H. Rigg

St. Francisville

Phone: 57R2 and 169F22, or

C. G. Stoll, M.D., Lawrenceville

LAWRENCE COUNTY: Sumner; population: 1,000. Trade area, 4,000. Only doctor called to service. Nearest doctor and hospital at Lawrenceville, 12 miles. New 100 bed modern nursing home, filled to 90% of capacity; 75 miles from Evansville, Ind. Modern office available. Financial assistance may be arranged. Agricultural and oil community. Churches: Christian, EUB, United Church of Christ and Free Methodist. Grade and high schools. State park with fishing facilities at edge of town. For further details contact: Mr. S. W. Lefler, 215 W. Locust St., Sumner.

LEE and DEKALB COUNTIES: Lee; population 250. Trade area, 2,000. Nearest doctor at Shabbona, 6 miles. Only doctor died in 1961. Nearest hospital, 20 miles,

at DeKalb. Rockford, 45 miles. Office and equipment of deceased doctor available if desired. Predominant nationality: Norwegian. Agricultural community. Churches: 2 Lutheran, Catholic, Methodist. For further information contact:

Mr. Berent Prestegard,
Mr. Art Erickson, or
John Engh, Lee

LEE COUNTY: Paw Paw; population: 1,000. Trade area, 2,500. Town without a physician since June 1, 1967. Nearest hospital at Mendota, 18 miles; 50 miles from Rockford, population 110,000. One prescription drug store. Office space available: 4 exam rooms, large reception room, store room, x-ray dark room. Office equipment available if desired. Agricultural area. Churches: 4 Protestant. Grade and high schools. For further information contact: Mr. Orville Englehart, Farm Implement Dealer, Paw Paw, phone: 3821.

LIVINGSTON COUNTY: Dwight; population: 3,100. Trade area, 15,000. Two practicing physicians, ages: 55, 63. Nearest hospital, 20 miles at Pontiac, 37 miles from Joliet. Local prescription store. Office space available. Predominant nationalities: Danish and Italian. Churches: 7 Protestant and Catholic. Grade and high schools. Local golf course. Financial assistance may be arranged. Agricultural community. Local coil factory. R. R. Donnelly and Sons to erect

a large plant. For further information contact: A. A. Steiniche, M.D., 107 E. Chipewa, Dwight.

LIVINGSTON COUNTY: Saunemin and Cullum. Population: Saunemin 400; Cullum 700. Only doctor died in 1961. Nearest hospital at Pontiac, 12 miles, 60 miles from Joliet. Office available in remodeled building. New building built by a doctor in Cullum. Predominant nationality: German, English. Agricultural community. Churches: 7 Protestant and Catholic. Grade and high schools. Golf and swimming facilities at Pontiac. For further information contact:

Mr. James S. Parsons, Saunemin
Dr. Carl Ward, Pontiac

LIVINGSTON COUNTY: Pontiac; population: 10,000. Trade area, 30,000. Chicago, 90 miles on route 66. Agricultural and industrial community. Three new plants in past two years; all parochial and public schools new in last 10 years. Churches: Protestant and Catholic. Good parks; swimming, boating, fishing and golf facilities. In last 6 months two doctors have died, one has retired; one about to retire. Four others will soon limit their activity. Opportunity for solo practice or association. For further information contact: Carl Ward, M.D., 601 W. Henry St., Pontiac. Phone: 844-1534.

"Sit down before fact as a little child, be prepared to give up every preconceived notion, follow humbly wherever and to whatever abysses nature leads, or you shall learn nothing."—Thomas Henry Huxley.

Modern Scientific Wonders

The modern world has so developed that it is nonsense to attempt to reduce its wonders to a mere seven. The opportunity is for a constellation of seven wonders: the seven architectural wonders, the seven engineering wonders, the seven medical wonders, and so on. Ignoring that opportunity, here are listed seven scientific triumphs:

- Electronic communications
- Wonder drugs
- X-rays
- Space exploration
- Data processing
- Atomic energy
- Electron-microscope

It is not to be hoped that all persons will readily agree. Certainly this age of plastics is a world wonder. If this list is protested, then prepare a different one! (Carey P. McCord, M.D. The Seven Modern Scientific Wonders of the World. *Jrnl. of Occ. Med.* [Sept.] 1968; 10:9; p. 569.)

Do you have patients who try to hide frustration behind conformity?

You see many depressed patients who hide their real anxieties behind a smoke screen of pretense. The more they try to conceal reality, the more entrenched the disturbances become. The role they assume is not adequate to suppress their inner turmoil. Unchecked, the turmoil finds expression in other symptoms.

They want your help and Aventyl HCl can help you.

Whether depression is open or secretive, Aventyl HCl assists in relieving the symptoms and the state of depression itself. It may aid in removing the emotional distortions and, in lifting the depression, help patients face, accept, or change their life patterns.



Eli Lilly and Company
Indianapolis
Indiana 46206

Helps remove the symptoms,
lift the depression,
and release the patient

Aventyl[®] HCl
Nortriptyline Hydrochloride

Laser Systems

Recent Legislation, Users, and Risks

The Illinois Department of Public Health has asked this Journal to publish the following material for the edification of Illinois physicians. Questions regarding items contained in the article should be addressed to the department, attention the Radiation Protection Advisory Council.

On Aug. 11, 1967, the Governor of Illinois signed Senate Bill #984 into a law designated as the Illinois Laser System Registration Act (Chapter 111½, Paragraphs 701-708, Revised Statutes, 1967) to become effective January 1, 1968. This law, the first of its kind in the nation, fixes responsibility in the Illinois Department of Public Health for the registration of all laser systems in the state, to investigate and inspect such systems, to require reporting of any accidental injuries sustained by such laser systems and to provide injunctive relief for violation of the act. Under the present statute, there are no controls for prevention of hazards but the act merely allows the Department to locate these systems and study the potentials for hazards associated with their use.

As of this reporting, there are 43 registered users in the State and 170 laser systems are utilized by these registrants. One university alone has 68 registered laser systems of commercial types and in addition, some 400-500 small experimental lasing devices in the Electronics Laboratory, although the latter are not such that they can be considered laser systems.

There are at least three manufacturers in Illinois who fabricate laser systems into a finished product. Applications are optical alignment instruments, printing press application, and educational optical devices.

Most of the registered laser systems are used in pure research. Industrial uses are primarily optical alignment of machinery, gauging, and, in one instance, to heat surfaces of ceramics in an industrial process.

There are two out-of-state distributors of laser systems who have voluntarily registered their facilities with the Department and three others who have expressed intent to register their agencies in Illinois.

The Department encourages the registration of such distributors in order to keep abreast of the rapidly growing uses and newer application techniques of lasers.

Lasers have found wide application in industry, government and research laboratories. Mass production and lower cost of these devices has made them readily available for use in schools and college labs. Never before has a major discovery been so readily available to so many people in such a short span of time.

Some fifty years elapsed from the time of the discovery of x-rays and radium before there was an awareness of the hazards in the uses of these radiations and before safety precautions were adopted to prevent the spread of radiation injury from these sources.

To date, there have not been any major injuries from lasers on human beings reported. However, there could be a real danger that the production and mass use of laser systems can be surpassing the understanding of their hazards. Medical research, which was initiated early in laser development, has shown that lasers do pose at least one major hazard to the individual. When the laser beam enters the lens of the eye, is concentrated, and strikes the retina, serious temporary or permanent damage can result. This potential eye hazard is complicated since because of the short duration of some of the laser pulses (on the order of micro or milliseconds) there may be no pain or discomfort when the beam strikes the retina, and further, these burns may take several days to become detectable under examination. To further complicate the hazard potential from these beams, if the beam is reflected from a diffuse surface the energy of the beam so reflected delivers nearly the same energy as the incident beam.

In addition to eye injury, some other potential hazards associated with laser use are: electrical shock, skin reactions, x-ray exposure, ozone production, oxygen depletion, nitrous oxide production, ignition of combustible solvents, explosion of pumping light, food contamination due to de-

position of vaporized toxic materials. The latter hazards are associated mostly with the more powerful lasers used industrially or in research projects.

In order to remain aware of the real and potential hazards due to this new science, industry must rely upon plant physicians, safety directors and laser workers.

All industrial physicians would be well advised to keep abreast of the medical aspects of laser hazards because it may well be in the not too distant future that a shipment of laboratory supplies or industrial machinery to his plant could include a potentially dangerous laser device. In such an event, the physician could ask for the cooperation of the safety director and the laser worker to keep him informed of any new developments in research activities which include lasers, or the installation of any new or more powerful equipment and also expansion of activities which would involve laser exposures of the attendant increase in manpower.

Lasers present a potential occupational health risk, and as such, the personnel employed in working with lasers should be subject to medical attention. A preoperational or pre-employment ophthalmological examination including a retinoscopy should be made and recorded as a basic picture from which to compare findings at future examinations. These records of findings can serve as evidence in disputed cases of eye injury and also as a check on gradual eye injury due to repeated eye

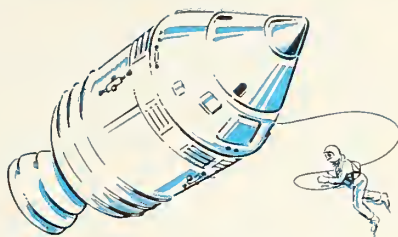
exposure to laser bombardment. Routine periodic examinations also should be carried out at intervals of six months or as judged by the plant physician.

In light of recent federal testimony regarding public exposure to ionizing radiations from color television sets, as well as radiations in the microwave and laser categories as expressed by the U.S. Public Health Service and other authorities, state legislation for locating and studying these newer types of radiations may well be in order. It is also of interest that since the inception of the Illinois legislation on lasers, a large number of states and some of the larger cities have expressed their interest in similar legislation. This is a healthy attitude in that it is believed to be in the best interest of the responsible user and employee to have the states and local authorities rather than the federal government administer legislation in this area.

In promulgating regulations authorized in the Illinois Act, especially relating to exempting certain laser systems from registration requirements, the Director is required to seek the advice and consultation of engineers, physicists, physicians, and other persons with special knowledge in the field of laser systems and of medical and biological effects of such laser systems. The Department is presently in the process of forming a Technical Advisory Committee on Lasers for guidance in unresolved matters relating to the technological and medical-biological aspects of laser use.

Heartburn in Pregnancy

Recently Lind and his co-workers have published a further report on manometric studies carried out on three small groups of women—non-pregnant, pregnant but without heartburn, and pregnant and suffering from heartburn. They found that during pregnancy there was an increase in intragastric pressure, the normal response to which was an increase in sphincteric pressure, which thus maintained competence at the gastroesophageal junction. In the pregnant women with heartburn there was no such response, and indeed the resting tone of the sphincter in these women was subnormal. Under these conditions the sphincter was incompetent and allowed acid reflux. The factors responsible for these deviations from normal remain to be elucidated, but in the meantime the customary measures of avoiding spicy food and sleeping with an extra pillow or two can be supplemented by taking pyridostigmine or oxethazine in combination with aluminium hydroxide gel and magnesium hydroxide, though it is still not clear to what extent the efficacy of these drugs is pharmacological. In any case the symptom nearly always disappears early in the Puerperium. Indeed, Lind confirmed in a few women that the pressures in the gastroesophageal sphincter returned to normal within six weeks after labor. But if severe heartburn persists postnatally hiatus hernia should not be excluded. (Heartburn in Pregnancy. *Brit. Med. J.* [July 13] 1968; pg. 74.)



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages

complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.



WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

Meeting Memos

Jan. 21—The Chicago Committee on Trauma of the American College of Surgeons, General Surgical Section, will hold its meeting from 8-10 p.m. at Cook County Hospital. The program will consist of case presentations in the field of general surgery.

Jan. 25—The American Medical Association, Committee on Medical Aspects of Automotive Safety, will hold an all day meeting at the Drake Hotel, Chicago.

Jan. 27-29—The Medical Assembly of Southwest Texas will hold its 33rd Annual Session in San Antonio, Texas. This year's postgraduate assembly will feature 18 speakers from 14 different medical specialties.

Feb. 3-5—The American College of Surgeons will hold the first of three sectional meetings in Omaha, Neb. General surgery, urology and orthopedic sessions will be featured.

Feb. 7-8—The Chicago Society of Cytology will hold its Fourth Regional Meeting. The program includes seminars, scientific papers and workshops and will be held at the Knickerbocker Hotel, Chicago.

Feb. 8—The American College of Physicians will hold its Downstate and Northern Illinois Regional Meeting in Springfield. For further information contact: Edward W. Cannady, M.D., 4601 State St., East St. Louis.

Feb. 8-13—The International Academy of Proctology will hold its 21st Annual Congress and Teaching Seminar in Hollywood, Fla. For further information contact: Executive Office, 147-41 Sanford Avenue, Flushing, N.Y. 11355.

Feb. 12—The University of Chicago Center for Continuing Education will present "Diagnosis and Management of Respiratory Insufficiency" as a part of its 1969 Frontiers of Medicine Series.

Feb. 16-18—Annual ISMS Washington ROUNDUP, Sheraton Park Hotel, Washington, D.C. Eminent speakers, members of Congress will meet and discuss vital issues with Illinois MDs.

Feb. 18—The International College of Surgeons Hall of Fame will present "Surgical Aspects of Mental Health," Manuel E. Lichtenstein, M.D., as a part of its Thirteenth Series of Lectures.

Feb. 20-21—The American Congress of Rehabilitation Medicine will hold its Second Interdisciplinary Forum in Houston, Texas. The theme of the Forum is "Will Vested Interests Make Comprehensive Health Care a Myth?" Attendance is limited to 300. Address all inquiries to the Congress at 30 N. Michigan, Chicago 60602.

Feb. 21-23—The American Society of Anesthesiologists presents its Symposium on Anesthesia for the Cancer Patient, in Houston, Texas.

Giant Duodenal Ulcer

It is important to be familiar with the roentgen appearance of giant duodenal ulcer because it has a grave prognosis if not recognized and treated. In our opinion it is not at all rare, but its diagnosis has been frequently missed because the X-ray films can be deceptive. Although only 42 confirmed cases have been reported in the world literature, we have collected in the past five years 30 proved cases at Hines Hospital, 25 of which were diagnosed correctly in the Department of Radiology.

The most useful roentgen signs are as follows: The crater generally takes the place of the duodenal bulb, and it may resemble one, but it is different because it has no mucosal folds, does not change in size and shape, and tends to remain filled on multiple films due to stenosis beyond the crater. Because it is a walled-off abscess, there is often a pressure-defect on the gastric antrum and the third portion of the duodenum. The crater sometimes has a nodular base because of penetration into the pancreas. There may be a persistent, unchanging round collection of air in the crater, especially on later postero-anterior films. (Israel E. Kirsh and Thomas Brendel. The Importance of Giant Duodenal Ulcer. Radiology [July] 1968; 91:1; pgs. 14-19.)



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Car Flips—Driver Breaks Leg

ous, Sept. 7. John P. Jones of
ane incurred a broken leg today
he was driving failed

Patrolman B. R. Brown, the car hit a
fire hydrant and flipped over on its top
Hasn't he had enough excitement for one day.

He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic $\frac{1}{4}$ grain sedative dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

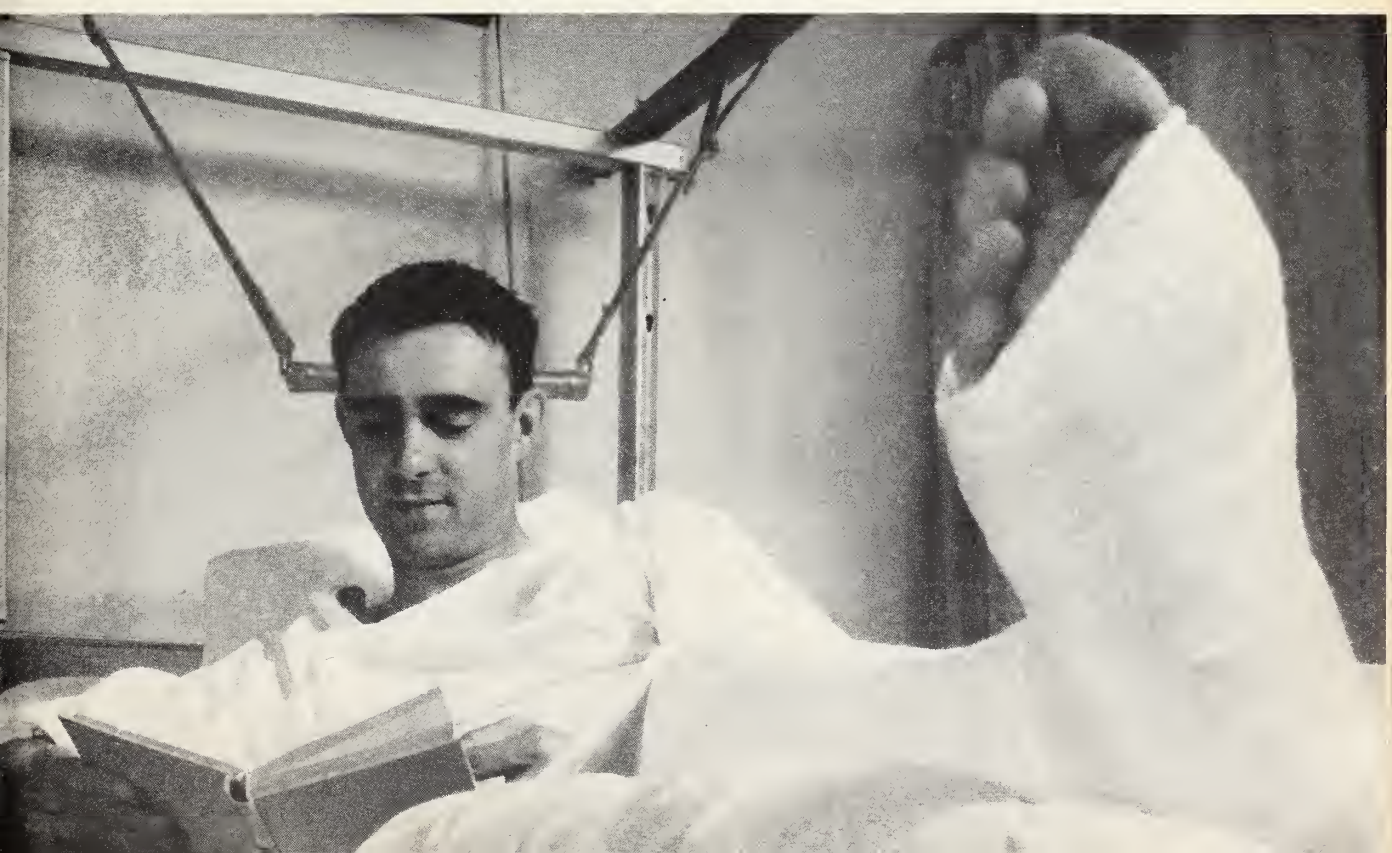
Phenaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: Phenobarbital ($\frac{1}{4}$ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin ($2\frac{1}{2}$ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, $\frac{1}{4}$ gr. (No. 2), $\frac{1}{2}$ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A. H. ROBINS COMPANY
RICHMOND, VA. 23220 **A-H-ROBINS**





Are We Dehumanizing Human Relations?

By WILBERT E. SCHEER

I've been in personnel work most of my adult life and I am concerned about the drift of personnel administration, which is a very personal service, toward impersonal procedures. Personnel administration has evolved into a series of unrelated techniques, run by master mechanics, according to the book, with little or no regard for the human beings they affect.

This is like the church organist who is a polished musician, but still the congregation can't sing with him. He is a mechanical player and does not have what we call the "churchfeel" that an organist needs to establish a mood. He plays with his head and hands, but not with his heart. In addition to knowing music, he has to know something about human nature.

A danger today is not in machines thinking like men, but in men thinking like machines. We worry about automation, then try to apply automation principles to human values. We in business have too much automation, not in machines and methods, but in the minds of men.

We can always invent a better milking machine, but we will still need the Cow. Let me digress for just a moment to share with you a description of the best example of automation that I can think of.

The Cow

A cow is a completely automated milk manufacturing machine. It is encased in un-tanned leather and mounted on four verticle movable supports, one on each corner. The front end of the machine, or input, contains the cutting and grinding mechanism, utilizing a unique feedback device. Here also are the headlights, air inlet and exhaust, a bumper and a fog-horn. At the rear, the machine carries the milk-dispensing equipment as well as a built-in fly swatter and insect repeller.

The central portion houses a hydro-chemical conversion unit. Briefly, this con-

sists of four fermentation and storage tanks connected in series by an intricate network of flexible plumbing. This part also contains the central heating plant complete with automatic temperature controls, pumping station, and main ventilating systems. The waste disposal apparatus is located to the rear of this central section.

Cows are available, fully assembled, in an assortment of sizes and colors. Production output ranges from two to twenty tons of milk per year. In brief, the main externally visible features of the cow are: two lookers, two hookers, four standers-uppers, four hanger-downers and a swishy-wishy.

There is a similar machine known as the bull. It gives no milk but it has other interesting uses.

Let's face it. We're living in a mechanistic world. We learn science, but we take human relations for granted. It is a fact that in our educational development we've neglected the obvious and found it more exciting to study things that are farthest away. The oldest study is that of the stars. We know all about the stars and planets but we still know little about the man right next to us. Because of tremendous scientific advancement, we now know what's on the other side of the moon; but we still don't know what's in the back of our wife's mind. The Russians know how to gauge and conquer the intricacies of outer space, so that they could conceivably land a man on the moon one of these days. But they still haven't learned how to live at peace with the creatures up there or with their brethren here on earth. For that matter, are we Americans any better?

Progress along scientific lines is to be encouraged, but no such advance should be made unless at the same time it im-

(Continued on page 98)

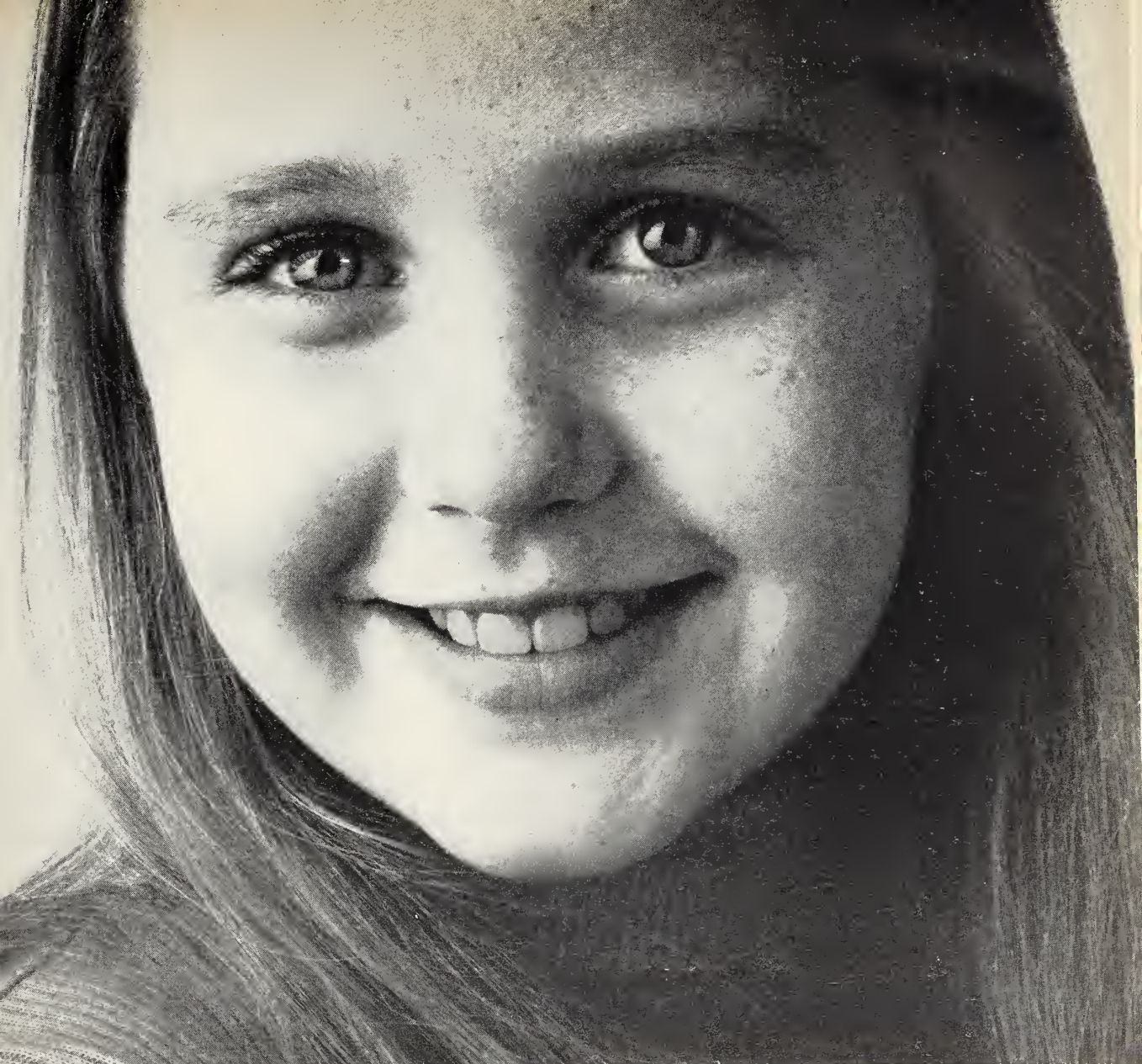


Photo professionally posed.

No injection after all! This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G; prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia.

In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**
(potassium phenoxymethyl penicillin) 

Medicine and Religion

Introduction to the Symposium On Abortion Papers

BY J. ERNEST BREED, M.D./CHICAGO

California and Colorado have liberalized their abortion laws to permit termination of pregnancy when it is believed the child will be defective, in case of rape, incest or when the pregnancy endangers the life of the mother. North Carolina, Georgia and Maryland also authorize therapeutic abortion in cases of fetal indications as well. This clause is also found in the Colorado law. Similar bills have been introduced in many other state legislatures. In order to bring this controversial problem before the public, the Illinois State Medical Society last winter arranged a television dialogue with both sides represented. A pediatrician, a psychiatrist, an obstetrician and a representative from the Public Health Department took part.

Under the auspices of the Committee on Religion and Medicine a second symposium was presented at the Illinois State Medical Society Convention in May, 1968. Since throughout history the clergy has been charged as keeper of the mores and since abortion, for whatever cause, has deep moral implications, it was fitting for this committee to provide an opportunity for the clergy to express their views. The papers of the three essayists are being published serially in the Illinois State Medical Society Journal as part of the report of the ISMS Committee on Religion and Medicine. The first, which follows this introduction, is entitled "Abortion: Jewish Law and the Law of the Land" and was presented by Rabbi Martin J. Goldman. The second paper, to be published next month, is entitled "Liberalized Abortion—A Precedent-Shattering Precedent." It presents the protestant attitude and was given by the Rev. Charles Carroll, Chaplain to Faculty and Students at the University of California. The third paper, to be published two months hence, entitled "Abortion—A Catholic View," was written by Charles J. Corcoran, O. P., Aquinas Institute, Dubuque, Iowa.

The demographers maintain that the population-food collision is already upon

us and that tens of millions now living are destined to starve to death. Japan resorted to legalized abortion when widely publicized birth control measures failed to limit rapid population increase. At this time about one and a half million abortions are recorded annually and it is believed nearly as many unrecorded operations are performed. Are the predictions of the demographers correct? Are those for whom we demand the right to live destined to suffer and die of starvation?

Experimental biologists are now fertilizing human ova in a test tube to observe the earliest changes in the embryo. Does this embryo have a soul? Does its discard constitute murder? Should these experiments be prohibited?

In our complex society not only adequate food and housing are essential, but expensive education is necessary if our children are going to be able to compete. Wishing to participate in the affluent society most so called middle and upper class families limit their progeny by birth control methods or by abortion. Is it realistic to believe this trend will be reversed? Are the parents, the abortionist, the police and the politicians who permit abortion rings, all to be given long term prison sentences as murderers? Should mass sterilization, as practiced in India, be embraced to control the "population explosion?" What, if anything, should parents do if their 12 year old daughter has been raped and is impregnated?

These essays are well written, convincing and strongly present the official position of these three established religions. There are, however, many dissenters among the clergy of each sect with the exception that Catholic priests are united in opposing abortions.

The public looks to the medical profession and to the clergy for answers to these profound questions. Read these articles carefully for your patients may want to know your opinion on liberalizing the abortion laws.

Abortion: Jewish Law and the Law of the Land

BY RABBI MARTIN J. GOLDMAN

Some see the entire question of abortion as a conflict between moral standards and social and economic needs; between public standards and individual aberrations; while others see in it a conflict between medicine and religion, or medicine and morality. One clergyman in criticizing medical groups who are pressing for modification of existing abortion laws, which would give the physicians far more discretionary power than they presently enjoy, states that "the decision of whether and under what circumstances it is right to destroy a germinating human life, depends on the assessment and weighing of values. Such value judgments are entirely outside the province of medical science." He concludes, "the decision on whether a human life once conceived is to be or not to be, properly belongs to moral experts or legislatures guided by such experts." Quite some time has passed since I read that statement and I have as yet not been able to locate any moral experts in the phone book or any other directory; nor have I seen records of them appearing at any court or at any of the local, state or federal legislatures.

Most discussions of abortion are similar to a scene in an American courtroom where there is a prosecutor, a defense lawyer, a jury and let us not forget the accused. One spokesman takes the part of the mother, another speaks for the child, one represents society, as such. Each sees only his own side of the problem and tries to convince the jury—the public—of the rightness or righteousness of his own view; the accused always being the one opposed to the speaker's conclusions.

In classical Jewish jurisprudence there was no defense lawyer nor prosecutor nor jury. The judges alone (23 of them in capital cases) tried to determine the facts, since no case is the same as any other, and watched over the rights of the accused and the protection of society. They determined the veracity of the facts through cross-examination of witnesses, and after conferring with each other and analyzing the pertinent material and legal precedents, came to a decision.

They tell of two plaintiffs who appeared before the Rabbi for arbitration. After listening to the first man the Rabbi said, "You are right." The opponent then presented his side of the case, whereupon the Rabbi said, "You are right." The Rabbi's wife who had been listening, asked him, "How could they both be right?" "You are right," the Rabbi answered. And I say the Rabbi was right. In other words, in any controversial issue, before a man in authority can give a decision, a right decision, he must see the rightness of both sides, or of all sides of the controversy. Only then can he weigh the factors which would determine on which side logic and justice is preponderant.

I can state in two minutes the position of Jewish law in regard to criminal abortion. Neither in the Bible, nor in the Mishnah and Talmud, nor in the Codes, is abortion mentioned as a penal crime in Jewish law. The only opinions expressed against abortion are found in the works of a philosopher, an historian and a mystic. The philosopher is Philo; the historian is Josephus Flavius; and the third, the mystic, is the author of the Zohar.

I will now continue and show how a people with no stated legal prohibition against abortion in its entire legal system was able to survive for four thousand years. And what Judaism has to say, indirectly, about abortion.

The Covenant Code (Ex., XXI:22-23) in the law of assault on a pregnant woman states that if men strive together and hurt a pregnant woman so that a miscarriage occurs and yet no harm follows, he shall pay a fine; but if any harm follows, then the regular laws of assault or homicide apply. The ancient Aramaic translations (Onkeles and Jonathan), the Syriac translation (Peshita), the Vulgata, Josephus, and the Rabbis in the Talmud, all explain that the first clause deals with an assault that resulted in a miscarriage only. The second clause deals with an assault that resulted in the death of the woman. The Septuagint (the Greek translation of the Bible), based on a mistranslation (followed by Philo), explains that this law does not deal with

any harm to the woman, but only with miscarriage. The first clause refers to a foetus that was not completely formed, therefore, the punishment is a fine; and the second clause refers to a fully formed foetus and the crime is therefore a capital offense. However, from the Rabbinic interpretation of the Biblical law it is clear that the killing of a foetus in any stage of development is not considered murder and is not punishable by death in Jewish law.

Another text important to our discussion is a ruling on therapeutic abortion, stated in the Mishnah. "In the case of a difficult birth, where the mother is in danger, one cuts up the child in her womb and extracts it member by member, because her life has priority over its life; but if the greater part of the head has emerged, one may not harm it, for one may not set aside one person's life for another." This ruling demonstrates that Jewish law not only sanctions embryotomy to save the mother's life, but is obligatory. You can also understand from this that only at the moment of birth does the child become a life, a being, a person.

The third source pertinent to this discussion has to do with a consideration of which has more priority, the life of a foetus or the mental suffering of the mother. It is found in the Mishnah. The background to this starts with the statement of the Rabbis of the Talmud that the commandment, "Thou shalt love thy neighbor as thyself," found in the book of Leviticus XIX:18, applies even to a condemned criminal, whose execution should not be cruel, and not be postponed. Any delay between the pronouncement of the death sentence and the execution must be avoided, since the criminal is sentenced to die, not to suffer. In the case of a woman who is accused of a capital crime and then found to be pregnant, either before or during her trial, the proceedings are postponed until she gives birth. If the death sentence was pronounced and she was then found to be pregnant, the Mishnah states that the execution must not be postponed until she gives birth, in order to avoid the agonizing suspense and mental anguish of the condemned woman. This ruling demonstrates that the avoidance of severe mental suffering on the part of the woman has priority over the life of the foetus in

Jewish law.

While it might appear that Jewish law did not show consideration for the foetus, from what I have quoted up 'till now, I'll now mention legislative measures found in the Talmud which indicate the attitude of Jewish law to the unborn child's claim to life, and the concern to safeguard the foetus in the mother's womb. I'll quote only a few of the many statements. Pregnant women were permitted to use a contraceptive, because at that time it was a worldwide belief that sexual relations were harmful to the foetus. The same reason also barred divorced or widowed women from remarriage while pregnant. Even the laws of the day of Atonement and the laws of the Sabbath were nullified when necessary to the safety of the foetus. If a pregnant woman died on the Sabbath it was obligatory to perform an operation to try to save the life of the child.

The foetus also was the subject of theological discussions; for example, the question of when a soul entered a person, at the time of conception, at formation or at birth. Various opinions were stated as to when an infant has a place in the world to come, or a share in the resurrection of the dead, ranging from conception, to birth or circumcision, or the ability to speak and respond Amen. In the Aggadic portions, personal functions and discernment are attributed to embryos, such as their participation in the song of Moses, in their acceptance of the Divine Law at Mt. Sinai, their malediction of sinners and David's composition of Psalms before his birth, and how the child in the womb is taught the Torah by an angel before it is born, and many more.

All these theological considerations, the Aggadic statements, and legislative measures, reflected a positive and deeply concerned attitude toward the foetus. These, together with the teaching of and the adherence to the general moral standards and the cohesiveness of the family, created a climate in which there was *no need* for a law against abortion. Only in cases where a serious conflict existed between the interest of the foetus and the physical or mental health of the mother, were decisions made in each case on an individual basis after considering all the factors.

In the last few centuries, specific cases of abortion are discussed in the Responsa

Literature. A grave psychological hazard to the mother was considered a reason for abortion as well as a physical threat. Another important question was at what stage of pregnancy abortion was to be considered. An affirmative decision was more likely in the early stages.

Up until now I have been reviewing the background of Jewish law in regard to the life of the foetus; now let us go on to consider the Jewish law in relation to the law of the land. No three words coming from any Rabbi of the Talmudic period have occasioned as much discussion on the part of scholars as Samuel's "dina demalkuta dina," the law of the land is the law. Nor is there any other Talmudic principle of such far reaching consequences for the system of Jewish civil law in its relation to the laws of the lands in which Jews have settled throughout the centuries. All subsequent Rabbinic authorities, in their discussions of Jewish civil law, had to take into account the law of the land. Therefore, in the United States, a case which the law of the state considers criminal abortion, would have to be considered illegal also in Jewish law.

After reviewing the history of abortion in Jewish law and life over a period of more than two thousand years, it is my opinion that the best solution to the problem of abortion in this country would be to eliminate abortion from the criminal code. No given set of liberalized or modified abortion laws will enable physicians to determine whether an abortion is the appropriate solution to the multi-faceted problems of a given pregnancy within the many life situations of the modern American society. Neither would any changes in existing laws satisfy all or a large number

of the conflicting groups now involved in the controversy.

There is a place for each and every one of the groups interested in abortion laws to play a part in solving the problems. I would rather see the legislator devote his abilities and energies to further the social and economic conditions of all our citizens. I would like to see clergymen instill in their congregants moral principles, both by teachings from the pulpit and direct personal communication. I would like to see the P.T.A.s and women's groups find ways and means of bringing back the cohesiveness of family life in America. The institutions of learning should teach along with the subject matter (whether it is biology, math, law or science), a sense of responsibility in using that knowledge in a total life situation. The schools should encourage early realistic sex education, higher standards of sexual conduct, and a greater sense of responsibility toward pregnancy.

The medical community has had a much more intimate exposure to the problems and needs for abortion than any other segment of society. Society has left the burden, by default, at the physician's doorstep. Let us not forget that the ethics of the medical profession have ingrained in the physician the desire to preserve life. No physician is unaware that by performing an abortion he is terminating life. I would have no hesitancy in leaving in the hands of a competent, conscientious and ethical physician, the final decision of whether an abortion is the best way to solve the problems of any given pregnancy, whether it be rape, deformity, mental or physical health.

Film Review

A 20-part series of medical education films on human anatomy, developed and produced over a period of 3½ years, is being distributed by Teaching Films, Inc., P. O. Box 66824, Houston, Tex. 77006. The films, averaging 12 minutes each, are available to medical, dental, and nursing schools, hospitals, and health institutes. Dissection and demonstrations are conducted in the anatomy laboratories of

Northwestern University. Called the "Cine-Prosector Series" these serve as an audio-visual tool which enables medical students and auxiliary personnel to better visualize and understand the details of anatomy without repeated prosection by the instructor. The films are available in either 8 mm. or 16 mm. with sound and are in color.

Clinics for Crippled Children

Twenty clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The Division will sponsor fourteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Feb. 5—Carlinville—Carlinville Area Hospital
- Feb. 5—Rock Island Cerebral Palsy—3808 Eighth Avenue
- Feb. 5—Hinsdale—Hinsdale Sanitarium
- Feb. 6—Lake County Cardiac — Victory Memorial Hospital
- Feb. 11—East St. Louis—Christian Welfare Hospital
- Feb. 11—Peoria General—Children's Hospital
- Feb. 12—Champaign-Urbana — McKinley Hospital

- Feb. 13—Springfield General — St. John's Hospital
- Feb. 13—Anna—First Christian Church
- Feb. 13—Rockford—St. Anthony Hospital
- Feb. 14—Chicago Heights Cardiac — St. Jame's Hospital
- Feb. 14—Evanston—St. Francis Hospital
- Feb. 18—Belleville—St. Elizabeth's Hospital
- Feb. 19—Chicago Heights General — St. Jame's Hospital
- Feb. 20—Elmhurst Cardiac—Memorial Hospital of DuPage County
- Feb. 20—Bloomington—St. Joseph Hospital
- Feb. 21—Chicago Heights Cardiac — St. Jame's Hospital
- Feb. 25—Peoria General—Children's Hospital
- Feb. 26—Springfield Cerebral Palsy — Diocesan Center
- Feb. 26—Aurora—Copley Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.



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NEW

PHARMACEUTICAL

SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

DUPLICATE SINGLE PRODUCTS

KAOCHLOR Liquid Potassium Supplement R
Manufacturer: Warren-Teed Pharmaceuticals, Inc.

Nonproprietary Name: Potassium chloride

Indications: Hypokalemic-hypochloremic alkalosis, hypokalemia secondary to diuretic or corticosteroid administration, cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adinamia episodica hereditaria, acute dehydration, heat cramps, and hyperkalemia from any cause.

Dosage: One tbsp. in at least 3 oz. water or citrus juices, twice daily, after meals.

Supplied: Liquid—10%, bottles of 1 pint and 1

gallon.

PERSADOX Derm. Prep—Other

o-t-c

Manufacturer: Texas Pharmacal Co.

Nonproprietary Name: Benzoyl peroxide

Indications: Adjunctive treatment of acne.

Contraindications: Do not use on the eyelids, mucous membranes, highly inflamed or denuded skin. Not for infants or small children. Not for ophthalmic use.

Dosage: Apply topically 1-3 times daily.

Supplied: Cream—5% in Cetaphil base, jars of 1 oz.

Lotion—5% in Cetaphil base, plastic bottles of 1 oz.

COMBINATION PRODUCTS

DOR-C Cold Prep.—General

o-t-c

Manufacturer: Dorsey Laboratories

Composition: Phenylpropanolamine HCl 6.25 mg.

Chlorpheniramine maleate 0.5 mg.

Indications: Children's nasal congestion due to the common cold or nasal allergies.

Contraindications: None mentioned.

Dosage: Children—6 to 12 yrs.: 2 tabs. q.i.d. Not for children under 6 yrs. unless recommended by physician.

Supplied: Tablets, chewable—bottles of 40.

GELUSIL-M G.I. Prep.—Antacids

o-t-c

Manufacturer: Warner-Chilcott Laboratories

Composition: Each 5cc. contains:

Magnesium trisilicate 0.50 gm.

Aluminum hydroxide 0.25 gm.

Magnesium hydroxide 0.20 gm.

with spearmint flavor.

Indications: Symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Contraindications: None mentioned.

Dosage: One to two tsp. between meals and at bedtime, or whenever symptoms occur.

Supplied: Bottles—6 and 12 fl. oz.

Technical Progress and a Changing World

We are constantly told in these days that we are living in a changing world. This is undoubtedly true, but there is nothing new about change—it has characterized the whole history of mankind and will doubtless continue to do so. The only new thing is the rate of change. When one looks back over the centuries one sees continual change in social attitudes and social values in human societies brought about by technological advances (that is, by the application of discovery or invention to practical ends—military, agricultural, medical, industrial, or administrative). Every technological advance widens horizons in some degree and extends the range of choices that are open to man; this compels in turn changes in social values and attitudes, some of which may be temporarily unpleasant for at least some sections of the community. But perhaps because technological progress depended in the past on chance invention or discovery, and because it took a long time for a new advance to come into general use, society managed to absorb it for many centuries without too much disturbance. Man seeks stability in his lifetime, and so long as change occurred slowly enough not to disturb matters too radically within the space of one man's life it could be absorbed by society without too much upheaval. (Lord Todd. *The Doctor in a Changing World*. Brit. Med. J. [Oct. 26] 1968; 4:5625; pgs. 207-209.)

Dehumanizing Human Relations

(Continued from page 90)

proves the human consideration. After all, whom else are we trying to benefit by these technological changes except people.

The worker must see that his contribution flows into the common ocean of human effort. The telephone lineman is not merely tying two strands of wire together, he is linking patient to doctor. That record that you file, the bill you prepare, the Physician's Care Report you submit to Blue Shield—these are not pieces of paper; behind each piece of paper is a human being who came to your office for your sympathetic understanding of his personal problem, and who looks to you for good paperwork administration, of course, but much more, oh, so much more.

Your success for your employer and your clients rests on good human relations, kept personal, in a climate of respect and dignity. For that matter, this is the answer to the problems of man, of companies, of nations, and of the world.

A father thinking he could divert his

small son for a few minutes while he was attempting to read the newspaper, tore a map of the world from a magazine, cut it into jigsaw pieces and said, "Here, put this together, and when you have it finished, I'll put aside my paper and play with you."

The father settled back, confident that he wouldn't be bothered for some time. In a few minutes, however, the boy was back at his father's coat sleeve. Amazed, the father asked, "How did you finish so soon?" His son answered, "Well you see, Daddy, there was a picture of a man on the other side. I just put the man together and the world took care of itself."

We can build a peaceful nation by helping people live peaceably among themselves. Medical assistants can build a better professional service by not dehumanizing the human relations upon which the success of your very personal business rests.

Illinois' average unemployment compensation tax rate is the lowest in the nation and in 1967 was the lowest in Illinois history.

FOURTEENTH ANNUAL

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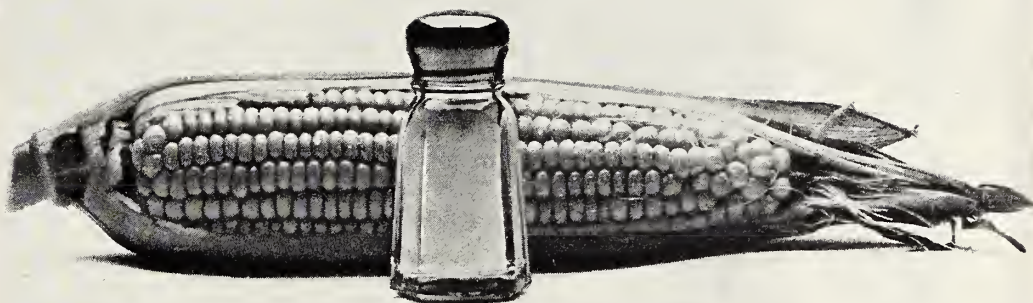
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Membership Forum

Dear Doctor:

There is considerable concern today over the spiraling costs of medical services. It behooves the medical profession to take a close look at the factors affecting health care costs. They must be concerned with influencing those factors that lie within their province and to enlist the aid of other agencies, and the public itself, in effecting economies. Public and governmental criticism of rising health costs directed at least in part toward the medical profession could be overcome to a great extent by a concerted effort on the part of the physicians to curb rising costs. *This does not mean a reduction in doctors' fees.* A study of the factors accounting for health care expenditures reveals that physicians' fees play only a small part in rising health care costs. We are, none the less, in a position to influence those factors which do play a major role. Since physicians are responsible for hospitalizing and ordering for patients they must not only become cost conscious, but help educate the patient to cost consciousness. We must help him recognize that regardless of who is paying the bill there is no such thing as free care.

Cost consciousness may mean more effective utilization of facilities and shorter hospital stays—sometimes over patient and family protests, formation and utilization of extended care and home health care facilities, and efficient and intelligent use of laboratory and x-ray facilities. I am sure we are all aware of practices that in the care of hospitalized patients could be changed to effect economies and yet not sacrifice quality of care. We must continue efforts with hospital administrations to cut rising costs by encouraging the most efficient use of area wide facilities and person-

nel. We must utilize our talents and knowledge in assisting insurance companies to write contracts which encourage the use of out-patient, office and home-health-care facilities. This would help considerably to reduce overall expenditures for health care.

The training of new personnel in the health fields who might assume many of the tasks that are now performed by the doctors and nurses should lower costs and increase the health manpower pool. We must urge changes in medical education which will allow the training of more physicians in shorter periods of time and innovations in curriculum which will orient the student more toward the clinical practice of medicine.

It is apparent that much of the blame for the increasing expenditures for health care lies with the public itself. Industry, labor and the health professions must combine in a massive effort to educate the public to conserve health care resources and the health care dollar. There is a tendency for the insured public to over-utilize health care facilities, not recognizing that this in turn is reflected in rising premiums for care. The physicians of this country have a unique opportunity to affect health care expenditures and to show to an increasingly critical public that we are concerned. While we are still in the position to be the guardians of costs let us assume that responsibility while there is yet time.

J. L. Gibbs, M.D.

Chairman, Council on Medical Education
Illinois State Medical Society

A new medical film slide series, 36 slides on Infections of Bone (Catalog Number 6-7A), is now available from the Medical Film Slide Division of Micro X-Ray Recorder, Inc. Compiled by Howard L. Steinbach, M.D., and R. H. Gold, M.D., of the University of California, the new slide series is valuable as a teaching aid, a reference tool for school and hospital libraries, or for individual research. Price of the series is \$16.50. For a free catalog and further details write: Micro X-Ray Recorder, Inc., Medical Film Slide Division, 3755 W. Lawrence Ave., Chicago, Ill. 60625.

Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.

Obituaries

Dr. Lillian G. Barsky, Maywood, died Aug. 11 at the age of 43.

***Dr. William J. Bryan**, Rock River Valley, Calif., former medical director of the Rockford Municipal Tuberculosis Sanitarium; died Nov. 15 at the age of 72. He was a past president of Winnebago County Medical Society.

***Dr. Jacob S. Fishman**, Chicago, died Nov. 10 at the age of 60.

***Dr. C. Roy Johnston**, Seattle, Wash., died Oct. 24 at the age of 87. He was former chief of staff at Decatur and Macon County Hospital, president of the Decatur Medical Society, president of the Tuberculosis Society and a member of ISMS Fifty-Year Club.

Dr. Arthur L. Kelly, Chicago, died Nov. 26 at the age of 73.

***Dr. Ernest Larson**, Chicago, a surgeon in South Shore Hospital and a past president, died Nov. 9 at the age of 71.

***Dr. Harry E. Lore, Jr.**, St. Louis, died Nov. 2 at the age of 47. He was a member of the American Academy of Ophthalmology, American Otorhinologic Society for Plastic Surgery, Illinois Society of Ophthalmology and Otolaryngology and past secretary of the Champaign County Medical Society.

Dr. Nathan A. Masor, Evanston, died July 12 at the age of 59.

***Dr. Elmer L. Mertz**, Lake Helen, Fla., a former Rockford physician for 40 years, died Nov. 19 at the age of 83. He was a member of ISMS Fifty-Year Club.

Dr. Fred R. Schwartz, Evanston, died Oct. 29 at the age of 58.

***Dr. Alvin B. Snider**, Blue Island, died June 12 at the age of 90. He was a member of ISMS Fifty-Year Club.

***Dr. Felix W. Sokolowski**, Alton, former superintendent of Alton State Hospital, died Nov. 9 at the age of 66.

***Dr. Raymond Sorensen**, Des Plaines, died Nov. 11 at the age of 58.

***Dr. Wilmier M. Talbert**, Decatur, died Oct. 30 at the age of 66. He was regional director of the west central region of the Illinois Department of Public Health.

*Indicates member of Illinois State Medical Society.

The VA trained more than 40,000 medical specialists at its 166 hospitals last year.

COOK COUNTY Graduate School of Medicine CONTINUING EDUCATION COURSES STARTING DATES—1969

SPECIALTY REVIEW COURSE IN SURGERY, Part II, Feb. 24
SPECIALTY REVIEW COURSE IN MEDICINE, Part II, March 3
SPECIALTY REVIEW COURSE IN THORACIC SURGERY, March 10
SPECIALTY REVIEW COURSE IN GENERAL PRACTICE, March 17
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
FLUIDS & ELECTROLYTES, One Week, April 21
VAGINAL APPROACH TO PELVIC SURGERY, One Week, March 24
FIBEROPTIC CULDOSCOPY & PELVIC PERITONEOSCOPY, March 17
PERITONEOSCOPY, Two Weeks, March 17
ULTRAVIOLET CYSTOSCOPY, 1½ Days, March 24
ADVANCES IN UROLOGY, Two Days, March 25
PEDIATRIC UROLOGY, Two Days, March 27
ADVANCES IN SURGERY, One Week, April 28
ESOPHAGEAL SURGERY, Three Days, March 27
BASIC INTERNAL MEDICINE, One Week, April 14
BASIC ELECTROCARDIOGRAPHY, One Week, March 10
RADIOISOTOPES, One or Two Weeks, First Monday each Month

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— THE VIEW BOX —

(Continued from page 58)

Diagnosis: Stein-Levinthal syndrome.

The classical radiographic features of a fairly symmetrical globular ovarian enlargement and often a small uterus with the clinical syndrome of oligomenorrhea or amenorrhea, some anovulatory cycles, hirsutism without masculinization, ovarian polycystic disease and infertility has been called the Stein-Levinthal syndrome. Wedge resection of the ovaries in carefully selected cases has in Stein's hands resulted in 89% fertility rate. The x-ray picture demonstrates that each ovary (seen as bilateral structures adjacent to the mid-line central structure of the uterus) is roughly equivalent to about the size of the uterus. The density seen immediately above the

pubic rami represents the urinary bladder. The patient has a total of 1000 to 1200 cc. of nitric oxide introduced intraperitoneally via a 20 gauge needle in the left subcostal region. The patient is then tilted into a 45 degree head down position and the tube is then centered directly perpendicular to the pelvis. An additional 10 and 20 degree angulation film is also taken. This introduction of a gas contrast media beautifully outlines the soft tissues of the uterus, broad ligaments and ovaries, and is a base line of this entire diagnostic examination. Experience with the procedure has been highly gratifying and there have been no serious complications.

Film Review

"A Concept of Family Life Education" is the title of a new film which depicts the role of the family environment and the school in the sex education of the young. The 16mm., color, 18 minute film, was premiered at the recent meeting of the American College of Obstetricians and Gynecologists. In addition, a new film brochure entitled "Family Life (Sex) Education—A Professional Responsibility" is also available from the film's producers, Ortho Pharmaceutical Corp. of Raritan, New Jersey 08869.

An honest and accurate documentary designed to convey the facts about LSD is now available from Professional Arts Incorporated, P.O. Box 8484, Universal City, Calif., 91608. Produced for the San Mateo California Union High School District in cooperation with the County Medical Society, the 27 minute film is recommended for all audiences above junior high school level and may be purchased or rented.

"Escape To Nowhere" is the title of a new film which depicts a real life story of drug use told "like it is" by kids who use drugs. The film, which attempts to reach young people with a persuasive message about the futility of using drugs, runs 25 minutes and may be rented or purchased from Professional Arts Incorporated, P.O. Box 8484, Universal City, Calif. 91608

Fatal Hemorrhage

(Continued from page 29)

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BLUE SHIELD REPORT



FOR *Illinois Physicians*

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Vol. 3, No. 2

February, 1969

BLUE CROSS-BLUE SHIELD OFFERS NEW PROGRAM

Illinois Blue Cross and Blue Shield are offering greater hospital and medical care protection to small groups in Illinois which was formerly available only to groups of fifty or more.

This superior program has been available since February 1 of this year.

Our Series B Plan offers a wide range of basic health care protection to groups as small as four. The Series B Plan will pay 80% of hospital charges and 80% of Usual and Customary charges of physicians for covered services that include the following:

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Radiation Therapy
Oxygen
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Out-patient Emergency
Accident Care,
Within 72 hours

Professional Services

Surgery, wherever performed
In-Hospital Medical Care
Delivery
Diagnostic X-Ray
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Pathology Services
Anesthesia Services
Radiation Therapy
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Emergency Accident Care, Within 72 hours

Groups of fifteen or more may choose to enroll in our Series A Plan which pays 100% of hospital charges and 100% of the Usual and Customary charges of physicians for the same services listed above.

In addition, Blue Shield members enrolled in the Series A Plan are also protected by our Major Health Expense coverage in the event of prolonged illness. Our Major Health Expense protection, after a \$100 deductible, will pay for hospital and doctors' charges not covered under the basic plan, prescription drugs, private duty nurses when medically necessary, approved extended care facilities, home and office calls, ambulance service, and for

other medical expenses.

Unmarried children up to age twenty-three are also protected by these new programs.

Payment on the basis of Usual and Customary fees included in our Series A & B Plans has been extended to smaller groups after the profession and our subscribers demonstrated their interest.

Illinois Blue Shield offered its Usual and Customary Plan for the first time in August 1967 after obtaining approval from the House of Delegates of the Illinois State Medical Society to apply the Society's definitions of Usual, Customary, and Reasonable to new Blue Shield accounts and to make payments to physicians on that basis.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

PAYMENTS FOR PROFESSIONAL SERVICES

In December of 1968 the Social Security Administration mailed to all Part B Medicare carriers a letter emphasizing the statutes and regulations governing payments made on a reasonable charge determination.

The reasonable charge criteria and the manner in which it has been applied has been intensively reviewed by the Social Security Administration in the light of experiences of the Medicare program and the carriers.

The letter from the Social Security Administration points to the need for controls in the application of reasonable charge criteria in view of rising medical costs. Strict and uniform application of reasonable charge criteria will assure that Part B payments are reasonable and will include reasonable constraints against rising costs.

The Social Security Administration also outlines the procedure to be followed if a physician finds it necessary to change his usual fee. One important feature of the directive is that carriers must be allowed time to obtain "acceptable data" to establish that a physician has a new usual charge for that particular service.

If a physician has made a prior change in his fee, an appropriate period must pass before it can again be revised.

In all instances, a revision of physician charges for medicare patients must be determined on the basis of data derived from all claims received during a reasonable period.

The Customary charges, those charges "most frequently and most widely used," in a locality have to be used for the purpose of setting the outer limits of Medicare's financial liability.

The regulations are stated very clearly and establish mathematically what these outer limits shall be and a "trailing off" of payments beyond the limits will not be allowed.

The fees which are determined to be the maximum customary payment for a given service in a locality may be revised but only after sufficient time has passed since the prior change.

This letter also points out that the Social Security Administration regulations requiring itemization of charges must be enforced before payments can be made. It was also made clear that when a physician bills for services actually performed outside his office, such as laboratory work performed by an independent laboratory, the charge to the patient must be "closely connected to what the laboratory charges the physician."

The Social Security Administration also indicated

that it has detected a trend among physicians to itemize charges when they have in the past made only one overall (package) charge for a series of services, i.e., pre- and post-operative care. When this does occur, the total payment cannot exceed the "reasonable" charge for the package.

The underscoring of these rules and regulations was brought about when Secretary Cohen announced on December 31 that the \$4.00 Part B premium would be continued through 1969-70 although actuaries had recommended that the rate be increased to \$4.40.

As Mr. Cohen pointed out in a letter sent to all physicians in January 1969 the continuance of "the \$4.00 rate is based on the assumption that the level of physicians fees to be reimbursed under the Medicare program and the level of the utilization of physician's services under the Medicare program will remain approximately at the level being currently experienced." In the same letter, Mr. Cohen stated that at the announcement of the rate continuance, he "strongly urged physicians to show voluntary restraint in connection with fee increases." He also "strongly urged all parties concerned to restrain unnecessary utilization of physicians' services."

Mr. Cohen closed by stating that the physicians and their government have a common goal: "the highest quality of medical services for all the American people with freedom on the part of each individual physician to care for his patients in accordance with his best medical judgment."

HOW TO SPEED PAYMENTS

In order for us to prevent delays in payments to physicians in the counties of Cook, DuPage, Kane, Lake, and Will where we serve as Part B Medicare carrier, we request that you submit separate "Request for Payment" SSA Forms 1490 for services rendered in 1968 and 1969. When we receive a claim with dates of service extending in two calendar years, we must separate the charges for the two years and process them as two different claims. This could delay payment to you and means you will receive a "split-payment", i.e., two checks which could result in confusion for your assistant.

It is necessary for us to separate charges in order to determine accurately the Medicare beneficiary's responsibility to pay the annual deductible.

Delays in payment also result from reporting incomplete information necessary to process the claim. Information most often omitted from the "Request for Payment" Form 1490 or itemized statement include: diagnosis; exact or inclusive dates of services; individual charges for each service rendered; description of services rendered; the place where the service was rendered.

In order to speed payments on your claim, it is advisable that all "Request for Payment" forms or itemized statements contain all of the needed information.

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Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
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alcohol†
† Some Loss
Unavoidable.

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In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

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The president's page



Philip G. Thomsen, M.D.

Let's Get Involved

We physicians must play an early and vigorous role in Comprehensive Health Planning.

We must be in there helping pour the cement—before the program hardens into shapes that we deplore.

Too many of us, at present, are inclined to shun CHP.

Some physicians feel this way because they doubt its importance. They look upon it as three abstract words—and think it will remain an abstraction.

Other doctors are ignoring it for a totally different reason. They fear it unquestionably will mean federal inroads into every nook and cranny of health care. As if it were the Loch Ness Monster, they think the safest course is to avoid swimming in its waters.

I object to both attitudes.

It is true that Comprehensive Planning will be hazy for a while. It will flounder some in fruitless conferences, disagreements, group rivalries...it may, at the outset, produce little more than pious intentions. But CHP is too logical and vital a concept to flounder for long.

It offers long-overdue hope for concerted progress against a jumble of problems. It *will* attain vast importance for the simple reason that it *must*.

As presently conceived, CHP is a congressional invitation to state, area and local action, without being a mandate. The best way to keep it free and voluntary is to become its partner. It will indeed become

our federal master, though, if we fail.

Society will not tolerate endless foot-dragging on the problems that CHP can face—such as air, water and noise pollution, overcrowded hospital facilities, shortages of health-care manpower, high disease and mortality rates in “inner cities,” the neglect of rural areas, unwholesome and stifling environments.

We physicians should regard CHP as an instrument against these problems . . . as a way to ease any stigma we suffer as a result of them.

Let us move ahead at the grassroots on CHP—and keep the program centered at the grassroots. Local direction can best define most of the problems, achieve cooperation and find plausible answers—while protecting the individual responsibilities of community institutions and agencies.

Our ISMS task force on Comprehensive Health Planning—headed by Dr. V. P. Siegel—is stimulating county medical societies to seize the initiative. It's doing an excellent job—and so are some of the county societies. With proper strength and fervor at the grassroots, Comprehensive Health Planning can be medical democracy in action!

Philip G. Thomsen M.D.

The Current Status of Human Heart Transplantation

BY RAYMOND E. REICH, M.D./HINSDALE

After over one year and some 100 plus heart transplants, three human heart transplant procedures were recently performed in Illinois by surgical teams headed by Dr. C. Frederick Kittle at Billings Hospital of the University of Chicago, by Dr. Hassen Najafi at Presbyterian-St. Lukes Hospital and by Dr. William E. Neville at the Veterans Hospital, Hines. In light of this, review of the current status of heart transplantation seems pertinent.

When Dr. Christiaan Barnard performed the first successful human heart transplant surgery over one year ago the whole world applauded his seemingly singular boldness, courage and success. The fact is, however, his was not a feat of singlehandedness at all; for years large medical research centers across Illinois, the country, and indeed the world, have been doing experimental animal heart transplants in an effort to enable the cardiovascular surgeons to some degree actually effect such a procedure on a human being.

Raymond E. Reich, M.D., is a graduate of Chicago Medical School, did his internship at Cook County Hospital, and his residency in Internal Medicine at Mt. Sinai Hospital of Chicago and the Veterans Administration Hospital at Hines. He had a cardiology fellowship at Mt. Sinai Hospital, Chicago with a fellowship sponsored by the National Heart Institute of the National Institutes of Health.

Dr. Reich is on the faculty of the Chicago Medical School as an instructor in medicine and is attending physician and consultant at Holy Cross Hospital, Evangelical Hospital and Christ Community Hospital. He is board certified in Internal Medicine and a member of the American Society of Internal Medicine and the American College of Cardiology.

Dr. Barnard could indeed be likened to Dr. Roger Bannister who initially achieved the astonishing deed of running the mile in less than four minutes; up to that time breaking the four minute mile seemed possible but not very probable. After Dr. Bannister's successful effort, it seemed for a while that runners the world over were suddenly able to emulate his deed. Like Dr. Bannister, Dr. Barnard, whose initial success made all the following attempts seem feasible, was able to witness many similarly successful procedures.

What of these many heart transplants that have taken place? At this writing it would appear that about 40% have proven successful. Of those surviving patients, Dr. Barnard's second patient, Dr. Blalberg has been living a fairly comfortable life for over a year.

Surgery

The actual surgical procedure involved in cardiac transplantation should be performed at a medical center that has the necessary equipment to do open heart surgery, with a pump oxygenator to accomplish the necessary by-pass needed during the procedure. It goes without saying, of course, that a skilled surgical team that has done prior surgery and research in animal cardiac transplants should be available.

Since the human heart has its own electrical nerve system consisting of the S. A. node, A. V. node, and the bundle of His, such an operation is somewhat simplified as there is no important external nerve supply with which to be concerned.

The heart of the recipient is removed intact by incising both left and right atria (avoiding the aforementioned nerve bundle) and cutting through the aorta and pulmonary arteries at a point which will enable the distal segments to be sutured to the proximal ends of the donor vessels. At the same time this is being accomplished, other members of the surgical team are removing the donor heart intact by incising thru the left and right atria to preserve the nerve bundles and leaving suitable lengths of pulmonary arteries and aorta to suture to the respective parts of the recipient.

The removal of the donor heart can be done successfully within minutes and under these circumstances perfusion of the donor heart has not been found to be necessary.

The donor heart is then sutured into the chest of the recipient and in most cases when the clamps on the great vessels are relaxed a spontaneous heart beat has started. In cases where this does not occur, external stimulation is used, and when necessary, further stimulation can be given to adjust the rhythm to a satisfactory sinus beat. Post-operatively, of course, the patient should be followed by cardiac monitoring.

Even in the over-simplified version of surgery outlined here, the surgical procedure itself is not by any means the most difficult aspect of the entire operation.

Selection of Donors and Recipients

Of the many patients that have received heart transplants, an overwhelming majority had severe myocardial damage to their original hearts either because of arteriosclerosis or repeated coronary occlusions, and have been judged to have irreparable cardiac damage, with or without some degree of cardiac failure. Angina may have been present as well.

It is in this group, aged between 40 and 60, that most transplants have taken place and the most success noted. Some transplants have been done where recipient had congenital or rheumatic heart disease. At the present time this group is very small and therefore difficult to properly assess.

Ideally, a cardiac transplantation recipient candidate should be otherwise healthy; that is to say no renal, pulmonary,

liver or brain pathology.

The recipient candidate is then blood and serum typed, leucocyte typed and in some cases might even be biopsied to determine chromosome arrangement. Once a candidate has been completely worked up and typed the waiting period for a suitable donor begins.

While it has been estimated that there are perhaps 60,000 to 70,000 candidates for heart transplantation in the United States, the availability of donors is another problem.

In the over 100 cases that have been transplanted to date, the most success has come with recipients receiving the heart of a younger patient. At the present time the availability of younger donors resulting from accidental death, or from younger patients who have died of non-cardiac cause, is limited. In the United States there are perhaps 40,000 to 50,000 such deaths yearly. To the waiting recipient comes the big question, if a donor is available, are the tests done on leucocyte, blood, etc. compatible? Exhaustive tests and research have shown that very few donors are compatible; so few, in fact, that perhaps for every waiting recipient there may be only one hundred to five hundred compatible donor candidates who die accidentally in the United States every year.

In an attempt to overcome some of these problems a movement has been started in large cities across the country to attempt to type possible donor candidates as to leucocyte and blood type so that in the event of their deaths a readily available pool of donors would exist.

While this has been done in only small numbers, at least it is a small step in a giant direction.

Technical, Legal and Ethical Problems

Once a donor and a recipient have been successfully matched, there exist still further problems. When is a donor considered legally dead? There now seems to be a general agreement that "the time of death shall be determined by the physician in attendance upon the donor's terminal illness or certifying his death; and he shall not be a member of the team of surgeons which transplants the part to another individual."¹ This is done by determining cessation of heart beat, absence of pulse

and blood pressure, and E.E.G. evidence of no brain wave activity.

Another problem existant is that if the donor is willing to pledge part of his anatomy after death, what is to stop surviving kin from declaiming such an act? There is a legislative proposal called the "Anatomical Gift Act" which should solve this problem for all concerned.

Problems of Rejection

The main deterrent to heart transplantation, to date, has been that of rejection of the donor heart by the recipient. Despite the compatibility of the donor heart, sometime after cardiac transplantation the inevitable phenomenon of rejection occurs.

In simple terms the donor heart represents a foreign substance to the recipient's body and thus the recipient, thru the formation of antibodies and complement, will attempt to "reject" the transplanted heart. Most of the studies on antigen, antibody and complement formation have been done on kidney transplants, but we believe that the same processes occur in cardiac transplantation.

Certain recipient's blood and tissue cells produce substances such as antibodies which exist both in and on the surface of such cells, which, in conjunction with complement thru a complement fixation reaction, cause destruction of cells of the antigen coated donor cells (in this case the heart muscle cells or blood cells). This rejection, if unchecked, will ultimately lead to malfunction and destruction of the donor heart in the recipient, or will lead to all the known complications of a failing heart.

Signs and Symptoms of Rejection

The most striking and universal symptom noted in a heart transplant patient undergoing rejection is lethargy. Often prior to such clinical findings as rising temperature, rapid pulse and changing blood pressure, the presence of a lethargic patient will alert the team to impending rejection reaction.

Other laboratory findings of note are an increased white blood count, elevated erythrocyte sedimentation rate and increasing serum enzyme.

A significant finding has been noted on the electrocardiograms of patients with

transplanted hearts. A normal post-operative E. K. G. will show the presence of 2 P. waves, which is to be expected due to the preservation of both conduction systems in the transplanted heart, one from the donor in the donor's right atrium and one from the recipient in the recipient's right atrium. If rejection occurs it becomes apparent by a decreasing voltage of the R wave of the electrocardiogram as seen on serial tracings. As the patient recovers from the process of rejection a steadily increasing R wave signals recovery.

Treatment of Rejection

In the prophylaxis and management of rejection several drugs are most universally accepted for use. These include A.L.G. (anti-lymphocytic globulin) Immuran (first used with marked success in kidney transplants). Prednisone and several newer drugs are currently being tested.

This regime, of course, must be supplemented by all necessary antibiotics, blood, intravenous feedings, cardiac glycosides, diuretics and so forth, as each individual case may require. Most of the drugs are used in prophylaxis of rejection and are gradually increased to their maximum dosage as signs and symptoms of frank rejection appear.

The penultimate treatment of rejection is, of course, a second heart transplant. This has already been done in two cases, with poor results, but remains probably the final recourse in the treatment of rejection. Dr. Barnard stated that he would not hesitate to perform another transplant on his most successful patient, Dr. Blaiberg, if medical treatment of the rejection reaction was unsuccessful.

Costs

Another aspect of cardiac transplantation which may be most important in some cases is cost. It has been estimated in the many operations thus far performed that the cost is between thirty and forty thousand dollars per case. For this reason it would appear that at the present time most cardiac transplants must be performed at large medical centers with a considerable philanthropic endowment for cardiac research and surgery.

In summary, now that cardiac transplantation has become a reality in Illinois, it is important that all physicians be aware of the pitfalls and progress of this type of

Table I

Survival of Cardiac Transplant Patients*

Surgeon	Total	Surviving
Christiaan Barnard	3	2
Denton Cooley	17	6
Michael DeBakey	9	5
Norman Shumway	10	5
Pierre Grondin	9	5
Others	52	20
	100	43

* As of Dec. 6, 1968, the day the 100th transplant was accomplished by Israeli physicians. The longest survival has been 1 year. Six months survival, or more, applies to some 4 patients while another 25 have survived three months or more. Data from "Medical World News," Jan. 10, 1969.

surgery and its complications.

At this writing the transplant of one infant heart to another infant recipient (the youngest patient transplant yet attempted) as performed by a team headed by Dr. Kittle at Billings Hospital has proved to be unsuccessful. But as Dr. Kittle stated, "This has given us very valuable information for another attempt in the

future on patients in this age group."

The middle aged recipient of the heart of a young man in his twenties, at Presbyterian-St. Lukes Hospital, by a team headed by Dr. Najafi, is doing very well.

After a survival of 41½ hours, the 49 year old recipient of the third Illinois heart transplant expired. Complications were feared from the outset due to emphysema and damaged lungs. The recipient's heart had enlarged to four times its normal size due to cardiac myopathy.

The three clinical cases in Illinois, as well as the many other cases done in the past year all over the world, seem to indicate that this latest form of cardiovascular surgery, in spite of its inherent technical, legal and moral complications, is here to stay.

Reference

1. Proposed Uniform Anatomical Gift Act.

Successful Transplantations Noted

Another chapter was added to the history of medicine on January 2, 1968, when 58-year-old Dr. Philip Blaiberg—a Capetown, South Africa dentist—began life anew following a successful heart transplant performed by Dr. Christiaan Barnard.

Two and one-half months later, on Saturday, March 16, Dr. Blaiberg was released from the Hospital and is, at this writing, the longest-living survivor of such an operation. News of this dramatic event spread to every corner of the globe, and details and statistics of the transplant were demanded by both the public and the press. The first two human heart transplants took place on December 3, 1967 in Capetown, South Africa and December 6, 1967 in Brooklyn, New York, but the patients survived for only 18 days and 6½ hours, respectively.

As of January 19, 1969, 108 heart transplants had been performed, and 51 patients had survived the operation. Sixty-one took place in the United States (two of which were "second" transplants) and 47 were performed abroad. The two "second" transplants were completed on November 21. One was performed in Houston, Texas, at St. Luke's Episcopal Hospital, and the patient was listed as both the 9th and 83rd

heart transplant; the other was performed at the Stanford University Medical Center in Palo Alto, Calif., and the recipient was the 84th and 85th heart transplant.

Until the present immunosuppressive regimen was introduced in 1960, there were no significant survivals of patients receiving kidney homotransplants, except twins. Results of kidney transplantation have been improving steadily ever since. More than 2,000 kidney transplants have been accomplished, and some 1,100 survive. Over the past four years some 60% of the persons receiving transplants from related living donors survive. Of the patients who received kidneys from cadaver donors over four years ago 30% survive. It is interesting to note that the first successful human renal transplant was accomplished in Illinois, at Little Company of Mary Hospital, Evergreen Park.

Significant advance is being made in all areas of transplantation science. Cornea, cardiac, renal, liver, lung, pancreas, spleen, bowel, thymus, bone, skin, endocrine and marrow are some of the areas where experimentation and research are being conducted with intensity. Of these, some are at a much later stage of development than others. Corneal transplants, for example

have been performed successfully for many years—a two-fold accomplishment: a person is rehabilitated *and* returned to a productive role in society. The first orthotopic liver transplants were done in 1963-4. Of the ten accomplished the longest survival was 23 days. In 1967-8 there were 20 patients. With new procedures and new sera and improved tissue typing and matching, five survived from two to eight months. One survived to 13 months but expired due to an original cancer while the transplant continued to function well.

Transplantations of the entire lung and of lobes have been carried out. In the U.S. there have been three transplants of an en-

tire lung, in which cases the survival time has been eight days, 18 days and 27 days. One patient in Canada lived 7 days and one in Scotland 14 days. In Japan one case of lobe transplantation survived 18 days after which the lobe was removed.

Pancreas transplants, all done for diabetes, have been attempted in Brazil and in the United States. No long-term survival has been accomplished. The need for spleen transplantation is uncertain. In five attempts at this none have succeeded. Recently one patient received a spleen but it ruptured and had to be excised. The patient continues to survive.

The Uniform Anatomical Gift Act

Donation and procurement of tissue and organs may be effected from both living and dead persons. A basic consideration is that while a living person, who is a competent, adult individual, has the right to make such a donation, there is need to enact statutory regulations regarding the use of cadaver organs or tissue applicable in cases of survivor control. If use of an organ or tissue after death is involved, many questions of ethical or moral consideration are present. While the use of a living donor's tissue may raise the same issues, they are much more serious in the case of a deceased. This is partly due to several competing interests. These primarily would be: the wishes of the deceased, the wishes of the surviving spouse and next of kin, the needs for organs or tissue for medical education, research or transplant, and the need for the determination of cause of death.

Presently included in the Illinois Statutes is a law providing individual authority to donate, allowing donation by will, or by written instrument, and protecting physicians from civil liability. The pertinent rule is as follows (*Ill. Rev. Stat. 1967, Art. 3, part 42a, 1-2*):

42a. § 42a. Gift of Body.) 1. Every person of testamentary capacity may give by will or other written instrument executed during that person's lifetime, the whole or any part of his body to a charitable, educational or research institution, university, college, State Director of Public Health, State Director of Public Welfare, legally licensed hospital or any other organization intended and equipped to distribute human bodies or parts thereof, either for use as such institution, organization, university, college, Director or hospital may see fit, or for use as expressly designated in the will or other instrument, and the gift shall become effective immediately upon death.

2. If the instrument making the gift does not purport to be a will, it shall be executed by the donor or by some person in his presence and by his direction and attested in the presence of the donor by two or more credible witnesses. The instrument shall become immediately effective upon the donor's death, and no person acting in good faith pursuant to the direction of the instrument and without knowledge of a subsequent revocation thereof shall be liable for so doing, notwithstanding the subsequent revocation in whole or part by a will, codicil, or other instrument executed in accordance with this Section. Added by act approved July 10, 1959. L.1959, p. 799.

The National Conference of the Commissioners on Uniform State Laws, on July 30, 1968, met and approved the Uniform Anatomical Gift Act proposed to all states and designed to facilitate the donation and use of human tissues and organs for transplantation and other medical purposes. The Act received the endorsement of the American Bar Association on Aug. 7, 1968. It is designed to provide a favorable legal environment for activities in the donation and use of human tissue and organs.

This Uniform Act has been proposed in the belief that an individual should be able to control the disposition of his own body after death and that his wishes should not be frustrated. In drawing up the Act several safeguards have been included: the rights of the appropriate next of kin are provided for; physicians are protected; public interests in a dead body are maintained. It is the end result of over three years of intensive study by a special committee of the National Conference. This is particularly timely due to the many questions arising as a result of recent activity in the field of cardiac transplantation.

The suggested Universal Anatomical Gift Act is reproduced here to indicate the extent of its coverage. The Act provides a model relating to the gift and use of organs and tissue for transplant. This is a major step towards resolving the many legal un-

certainities in existence and at the same time remains cognizant of the need for unhindered medical judgment. The legal profession has reached a consensus in this complex area. The medical profession is progressing to such a consensus.

UNIFORM ANATOMICAL GIFT ACT

(Copy of final draft as approved on July 30, 1968, by the National Conference of Commissioners on Uniform State Laws)

An act authorizing the gift of all or part of a human body after death for specified purposes.

SECTION 1. (Definitions)

(a) "Bank or storage facility" means a facility licensed, accredited or approved under the laws of any state for storage of human bodies or parts thereof.

(b) "Decedent" means a deceased individual and includes a stillborn infant or fetus.

(c) "Donor" means an individual who makes a gift of all or part of his body.

(d) "Hospital" means a hospital licensed, accredited or approved under the laws of any state and includes a hospital operated by the United States government, a state or a subdivision thereof, although not required to be licensed under state laws.

(e) "Part" includes organs, tissues, eyes, bones, arteries, blood, other fluids and other portions of a human body, and "part" includes "parts."

(f) "Persons" means an individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association or any other legal entity.

(g) "Physician" or "surgeon" means a physician or surgeon licensed or authorized to practice under the laws of any state.

(h) "State" includes any state, district, commonwealth, territory, insular possession, and any other area subject to the legislative authority of the United States of America.

SECTION 2. (Persons Who May Execute an Anatomical Gift)

(a) Any individual of sound mind and 18 years of age or more may give all or any part of his body for any purposes specified in section 3, the gift to take effect upon death.

(b) Any of the following persons, in order of priority stated, when persons in prior classes are not available at the time of death, and in the absence of actual notice of contrary indications by the decedent, or actual notice of opposition by a member of the same or a prior class, may give all or any part of the decedent's body for any purposes specified in section 3.

(1) the spouse,

(2) an adult son or daughter,

(3) either parent,

(4) an adult brother or sister,

(5) a guardian of the person of the decedent at the time of his death,

(6) any other person authorized or under obligation to dispose of the body.

(c) If the donee has actual notice of contrary indications by the decedent, or that a gift by a member of a class is opposed by a member of the same or a prior class, the donee shall not accept the gift. The persons authorized by subsection (b) may make the gift after death or immediately before death.

(d) A gift of all or part of a body authorizes any examination necessary to assure medical acceptability of the gift for the purposes intended.

(e) The rights of the donee created by the gift

are paramount to the rights of others except as provided by section 7(d).

SECTION 3. (Persons Who May Become Donees, and Purposes for Which Anatomical Gifts May Be Made) The following persons may become donees of gifts of bodies or parts thereof for the purposes stated:

(1) any hospital, surgeon, or physician, for medical or dental education, research, advancement of medical or dental science, therapy or transplantation; or

(2) any accredited medical or dental school, college or university for education, research, advancement of medical or dental science or therapy; or

(3) any bank or storage facility for medical or dental education, research, advancement of medical or dental science, therapy or transplantation; or

(4) any specified individual for therapy or transplantation needed by him.

SECTION 4. (Manner of Executing Anatomical Gifts)

(a) A gift of all or part of the body under section 2 (a) may be made by will. The gift becomes effective upon the death of the testator without waiting for probate. If the will is not probated, or if it is declared invalid for testamentary purposes, the gift, to the extent that it has been acted upon in good faith, is nevertheless valid and effective.

(b) A gift of all or part of the body under section 2 (a) may also be made by document other than a will. The gift becomes effective upon the death of the donor. The document, which may be a card designed to be carried on the person, must be signed by the donor, in the presence of 2 witnesses who must sign the document in his presence. If the donor cannot sign, the document may be signed for him at his direction and in his presence, and in the presence of 2 witnesses who must sign the document in his presence. Delivery of the document of gift during the donor's lifetime is not necessary to make the gift valid.

(c) The gift may be made to a specified donee or without specifying a donee. If the latter, the gift may be accepted by the attending physician as donee upon or following death. If the gift is made to a specified donee who is not available at the time and place of death, the attending physician upon or following death, in the absence of any expressed indication that the donor desired otherwise, may accept the gift as donee. The physician who becomes a donee under this subsection shall not participate in the procedures for removing or transplanting a part.

(d) Notwithstanding section 7(b), the donor may designate in his will, card or other document of gift the surgeon or physician to carry out the appropriate procedures. In the absence of a designation, or if the designee is not available, the donee or other person authorized to accept the gift may employ or authorize any surgeon or physician for the purpose.

(e) Any gift by a person designated in section 2(b) shall be made by a document signed by him, or made by his telegraphic, recorded telephonic or other recorded message.

SECTION 5. (*Delivery of Document of Gift*) If the gift is made by the donor to a specified donee, the will, card, or other document, or an executed copy thereof, may be delivered to the donee to expedite the appropriate procedures immediately after death, but delivery is not necessary to the validity of the gift. The will, card or other document, or an executed copy thereof, may be deposited in any hospital, bank or storage facility or registry office that accepts them for safekeeping or for facilitation of procedures after death. On request of any interested party upon or after the donor's death, the person in possession shall produce the document for examination.

SECTION 6. (*Amendment or Revocation of the Gift*)

(a) If the will, card or other document or executed copy thereof has been delivered to a specified donee, the donor may amend or revoke the gift by:

(1) the execution and delivery to the donee of a signed statement, or

(2) an oral statement made in the presence of 2 persons and communicated to the donee, or

(3) a statement during a terminal illness or injury addressed to an attending physician and communicated to the donee, or

(4) a signed card or document found on his person or in his effects.

(b) Any document of gift which has not been delivered to the donee may be revoked by the donor in the manner set out in subsection (a) or by destruction, cancellation, or mutilation of the document and all executed copies thereof.

(c) Any gift made by a will may also be amended or revoked in the manner provided for amendment or revocation of wills, or as provided in subsection (a).

SECTION 7. (*Rights and Duties at Death*)

(a) The donee may accept or reject the gift. If the donee accepts a gift of the entire body, he may, subject to the terms of the gift, authorize embalming and the use of the body in funeral services. If the gift is of a part of the body, the donee, upon the death of the donor and prior to embalming, shall cause the part to be removed without unnecessary mutilation. After removal of the part, custody of the remainder of the body vests in the surviving spouse, next of kin or other persons under obligation to dispose of the body.

(b) The time of death shall be determined by a physician who attends the donor at his death, or, if none, the physician who certifies the death. This physician shall not participate in the procedures for removing or transplanting a part.

(c) A person who acts in good faith in accord with the terms of this Act, or under the anatomical gift laws of another state (or a foreign country) is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act.

(d) The provisions of this Act are subject to the laws of this state prescribing powers and duties with respect to autopsies.

SECTION 8. (*Uniformity of Interpretation*) This Act shall be so construed as to effectuate its general purpose to make uniform the law of those states which enact it.

SECTION 9. (*Short Title*) This Act may be cited as the Uniform Anatomical Gift Act.

Transplantation Registry Established

The American College of Surgeons has announced the establishment of a transplantation registry which will be housed at the group's Chicago headquarters.

The transplantation registry is being established in cooperation with the National Institutes of Health, the AMA, American College of Cardiology, National Research Council, American Heart Ass'n., American Cancer Society and the College of Chest Physicians. It will include heart, liver, lungs, spleen, pancreas, thymus, gonads and bone marrow, and will be under the supervision of a project coordinator. Dr. William E. Adams will serve as the Administrator.

Kidney transplants, which already number over 1,000 survivors, are being monitored by an effective kidney transplant registry, and will not be included.

In addition, transplantations performed abroad will also be included, pending the outcome of negotiations now being conducted between the College, federal agencies, and other countries.

LEGISLATIVE COUNCIL AND BOARD OF TRUSTEES AGREE TO BACK UNIFORM ACT

Meeting Saturday, January 11, the ISMS Council on Legislation discussed the needs in Illinois for expanded coverage in the field of anatomical gifts. The Universal Anatomical Gift Act was analyzed and weighed in light of current needs. After serious discussion the matter was set into form of a recommendation to the Board of Trustees.

The Board heard the recommendation at its session January 12, and adopted the following: "that the Illinois State Medical Society support legislation in line with the Uniform Anatomical Gift Act and that Legal Counsel be directed to make any necessary changes in the Uniform Act appropriate to Illinois Law."

Thus, the Uniform Act, if adopted in Illinois, will make possible a greater scope of activity in the field of transplantation. A uniform Act adopted by the several states will also enable greater interchange between the states and will protect the rights of individuals when away from their principal residence.

Transplant Center Planned

Plans for the development of an extensive organ transplant center have been announced by the University of Illinois Hospitals. A kidney transplant program has been underway at the Hospitals for some time, and the new center will allow for marked expansion of the program.

The Center will provide facilities for the pre- and post-operative care of patients receiving transplanted organs, including the kidney, liver and heart.

Researchers at the hospital emphasized the importance of transplanting organs only between patients who have compatible tissue antigens. These are similar to blood group types. Although tissue typing

is in its infancy compared to blood group typing, they emphasize that the success or failure of organ transplantation, to date, has correlated extremely well with the available techniques of tissue typing.

The transplantation of cadaver organs on a random basis has yielded rather low, long term success, while transplantation of the kidney from blood relatives, who are likely to have similar tissue group types, has been extremely successful.

Organ transplantation at the institution is now based on tissue typing, and the new facilities will permit rapid expansion of the program.

Cardiac Transplants in Illinois

Illinois' first heart transplant was performed on Christmas Day at the University of Chicago, Pritzker School of Medicine Hospitals and Clinics by C. Frederick Kittle, M.D., 47, professor of surgery and chief of cardiovascular surgery.

This "Christmas gift of a heart" was received by an eight-day-old Harvey infant suffering from "congenital defects of the heart not correctable by any known surgical procedures." The donor was a two-day-old infant who died of a birth defect of the brain.

In this five hour transplant operation, in which doctors found it necessary to use a heart-lung machine intermittently after the heart had been implanted, Dr. Kittle was assisted by Robert Repogle, M.D., assistant professor of surgery, and Magdi Yacoub, M.D., instructor in surgery, and two anesthesiologists.

Illinois' second heart transplant operation was performed a mere two days after the first. This one, performed by 38-year-old Hassen Najafi, M.D., Iranian specialist in open heart surgery, was done at Presbyterian-St. Luke's Hospital, Chicago, and has been a total success to date. It began at 2 a.m. on Dec. 27 and took approximately four hours, was performed by a 25 member surgical team comprised of 5 cardiologists, 5 nurses, 3 anesthesiologists, 2 nurse anesthetists, 3 surgical technicians and 7 surgeons; including Richard Carle-

ton, M.D., director of Presbyterian-St. Luke's cardiovascular section, and Ormand C. Julian, M.D., chairman of the hospital's division of surgery.

In this case, the 103rd heart recipient was 50-year-old Ervin Cramer, Stickney, who suffered from heart muscle disease. Mr. Cramer received the heart of a younger man who died after suffering head injuries.

A third heart recipient died 4½ hours after receiving a new heart. A former bus driver, 49 years old, received the heart of a younger man who died of a brain tumor. The recipient had been unable to work for ten years and his heart had grown to four or five times its normal size. He also suffered from emphysema and had lung damage. The transplant was accomplished by Dr. William E. Neville at the Hines V.A. Hospital. This was the world's 108th heart transplant. Dr. Neville was assisted by four surgeons, three anesthesiologists, and related staff under Dr. Robert Fruin, chief.

As for the future of heart transplants in Illinois, Dr. Najafi, who has performed over 250 open heart operations in the last year, has said that he doubts that "natural heart transplants will be the 'wave of the future' because the problem of availability will always exist."

"I would welcome development of an artificial heart," Dr. Najafi said.

Heart Voltage Regulation

A method of experimentally regulating natural voltage in heart muscle cells has been developed at The University of Chicago to help search for the cause of heart failure.

The method involves placing a micro-electrode into a small group of heart cells, injecting an electrical charge, and recording the resulting voltage of the heart muscle contraction.

According to Dr. Harry A. Fozzard, Associate Professor of Medicine and Physiology, different ion concentrations between the inside and outside of the cell cause every heart muscle cell to have approximately 1/10th voltage on the inside. When all the heart cells, acting together and electrically connected, become positive, a heart contraction takes place and the heart beats.

It is this electrical activity which is recorded on an electrocardiogram.

When the heart is functioning normally, he said, its natural pacemaker mechanism keeps the electrical charge even. However, when the oxygen supply to the heart is diminished or varied in illness, electrical activity becomes uneven. Serious disorders, including a heart attack, can then take place.

To understand this electrical activity, Dr. Fozzard is attempting to determine how electrical disturbance in the heart triggers contraction and how it determines, in part, the size of the contraction. Although the existence of this problem has been known for some time, technical means of examining it meaningfully have not been available until recently.

Medical Groups Differ on Releasing News to Public

Two major medical groups have adopted opposing positions concerning the release to the public of new surgical procedures, such as heart transplants.

The Executive Committee of the International Society of Cardiology has suggested that no new medical or surgical procedure be released in the lay press before it is "published in a reputable medical journal after full scientific evaluation."

A statement developed at a meeting in Geneva in May was sent to the Heart Association with the request that it be published. In the statement, the Committee declared that in recent times such experiments have become matters of "public entertainment and even sensationalism." One result of such a trend, it was said, would be to "indirectly misrepresent to the public, who are not in a position to judge the implications of such developments, the dangers and limitations inseparable from such procedures in their initial phase."

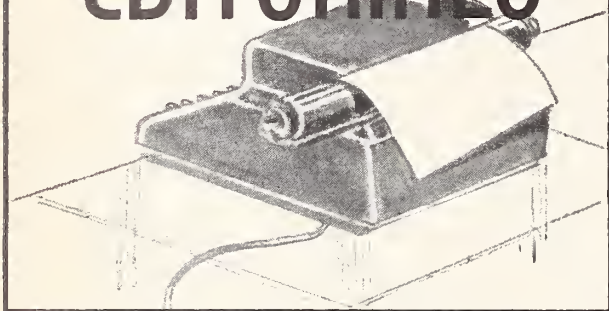
Delaying public release of such matters would avoid "extremes of anxiety or misplaced hope," the statement said. It urged the profession as a whole to support the view of initial publication in medical journals "in the interest firstly of the patient and secondly of their own standing and dignity."

In June, the American Medical Association's House of Delegates approved a statement on ethical guidelines in transplants offered by the Judicial Council. One of the seven points in the statement dealt with releasing information to the press.

"Medicine recognizes that organ transplants are newsworthy and that the public is entitled to be correctly informed about them," the statement said. It added that "normally, a scientific report of the procedures should first be made to the medical profession for review and evaluation. When dramatic aspects of medical advances prevent adherence to accepted procedures, objective, factual and discreet public reports to the communications media may be made by a properly authorized physician, but should be followed as soon as possible by full scientific reports to the profession."

(American Heart Association)

EDITORIALS



The moment of death is usually established by the physician. Life ends when the heart beat ceases and breathing stops; the brain usually dies within a few minutes. The latter is evident when muscular movement ceases, important reflexes such as those of the cornea cannot be elicited, and there is no response to sound or to pinch.

The situation has changed now that we have intensive care units with life-supporting equipment such as respirators and the pacemaker. The person is monitored and when the heart stops beating or breathing ceases, supportive measures appear to sustain life, even though the patient is unconscious. Is he alive or dead? Many who have undergone this ordeal have lived and are given a second chance to die.

Science has adequate evidence that the time of death should be advanced to coincide with brain death even though the heart and lungs are stimulated to function. For obvious reasons, this applies only to 2 or 3 per cent dying in the sophisticated surroundings of intensive care units. More than 95 per cent of the practitioners must rely on the old criteria for establishing death. When the individual dies in the home, at work or on the street, the physician must use his judgment relative to the use of artificial respiration and heart massage. These, however, are of little value if there are clinical signs of brain death. An electroencephalograph easily determines the latter but rarely is available in an emergency. Furthermore, society cannot afford the time and money to have the tracing made as a routine procedure.

THE TIME OF DEATH

The declaration of Sydney¹ is a statement on death that was adopted by the 22nd World Medical Assembly. It begins: "The determination of the time of death is in most countries the legal responsibility of the physician and should remain so. . . . The point of death of the different cells and organs is not so important as the certainty that the process has become irreversible by whatever techniques of resuscitation that may be employed. This determination will be based on clinical judgment supplemented if necessary by a number of diagnostic aids of which the electroencephalograph is currently the most helpful. . . . If the transplantation of an organ is involved, the decision that death exists should be made by two or more physicians and the physicians determining the moment of death should in no way be emotionally concerned with the performance of the transplantation." The last statement makes sense and should eliminate any criticism that the public and legal profession may have regarding organ transplantation.

When the patient is in an irreversible coma,² the physicians should not attempt to prolong life with supportive measures. These procedures do not prolong life; they prolong death. The physician should assume the responsibility of turning off the respirator or pacemaker.

T. R. Van Dellen, M.D.

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1. Statement on Death. The World Medical Association, Inc., New York (Sept.) 1968, Press Release.
2. Ethical Problems Created by the Hopelessly Unconscious Patient. Henry K. Beecher, M.D., *New England J. Med.* 278:26 (June 27) 1968, pp. 1425-1430.

A PLEA FOR ROUTINE EXAMINATION OF THE ENTIRE COMMON DUCT IN CHOLECYSTECTOMY

The initiate in abdominal surgery is thoroughly indoctrinated in all the possible anatomical anomalies of the extrabiliary tract. The importance of a thorough and comprehensive exposure of the biliary duct structures prior to the application of clamps or ligatures is repeatedly stressed and remains foremost in every surgeon's mind undertaking the removal of a diseased gallbladder. With time and experience, the virtue of this golden rule becomes unassailable.

The indications for exploring the common duct have similarly been drilled in the mind of the surgical resident and as we all know are: 1) a recent history of jaundice, 2) the presence of a dilated or thickened common duct, 3) palpable calculi, 4) the presence of small sized calculi in the gallbladder that could pass through the lumen of the cystic duct, and finally, 5) whenever in doubt. In the last several years, operative cholangiography has contributed to this final decision. This routinely used procedure, too, can be wrought with difficulties, such as prolonging operative time and obtaining false positive readings by injection of air bubbles. There are some surgeons, however, including this

author, who feel that operative cholangiography should always be performed following choledocholithotomy to obtain immediate assurance that no calculi were left behind. The value of this information prior to the closure of the abdominal incision is fundamentally obvious.

Although palpation of the supraduodenal portion of the common duct usually offers the desired information, it would seem logical that the common duct should be examined through its entire length, especially at its most narrow portion near the sphincter of Oddi. A lateral paraduodenal incision of the peritoneum and elevation of the duodenal "C" with blunt dissection can be done quickly and bloodlessly, permitting palpable access to the area of the papillae of Vater the retroduodenal portion of the common duct, terminal pancreatic ducts, and the head of the pancreas. This comprehensive information can be quickly and simply obtained and with just a few moments of additional operating time.

Therefore, it seems prudent that this "Kocher Maneuver" should be performed "routinely" in all cholecystectomies.

J. H. Sanders, M.D., F.A.C.S.

Cholesterol Kits

Barnett, Cash and Junghans reported their studies on the results obtained with the use of 12 different commercial "kits" for cholesterol analysis. These sets are designed for use in laboratories or doctors' offices whose work load does not justify training a technician to perform the tedious but reliable methods of Sperry and Webb² or Abell and Kendall.³ The authors who are experienced clinical chemists, found that 10 of 12 "kits" sold for the purpose did not perform satisfactorily in measuring serum cholesterol so far as either accuracy or reproducibility was concerned. One can only wonder what the results would be with even the two "successful" kits when they are used only occasionally in a doctor's office or small hospital, perhaps by a person whose training has not been in chemistry.

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THE VIEW BOX

By LEON LOVE, M.D.

*Director, Department of Diagnostic Radiology, Cook County Hospital,
and Clinical Professor of Radiology, Chicago Medical School*

A 27-year old Negro female with a five year history of hypertension despite anti-hypertensive medication. Intravenous pyelogram failed to show function of the right kidney. At cystoscopic examination the catheter was passed up the right ureter to the level of L4 at which point the contrast material returned into the bladder and no upper collecting system was demonstrated.

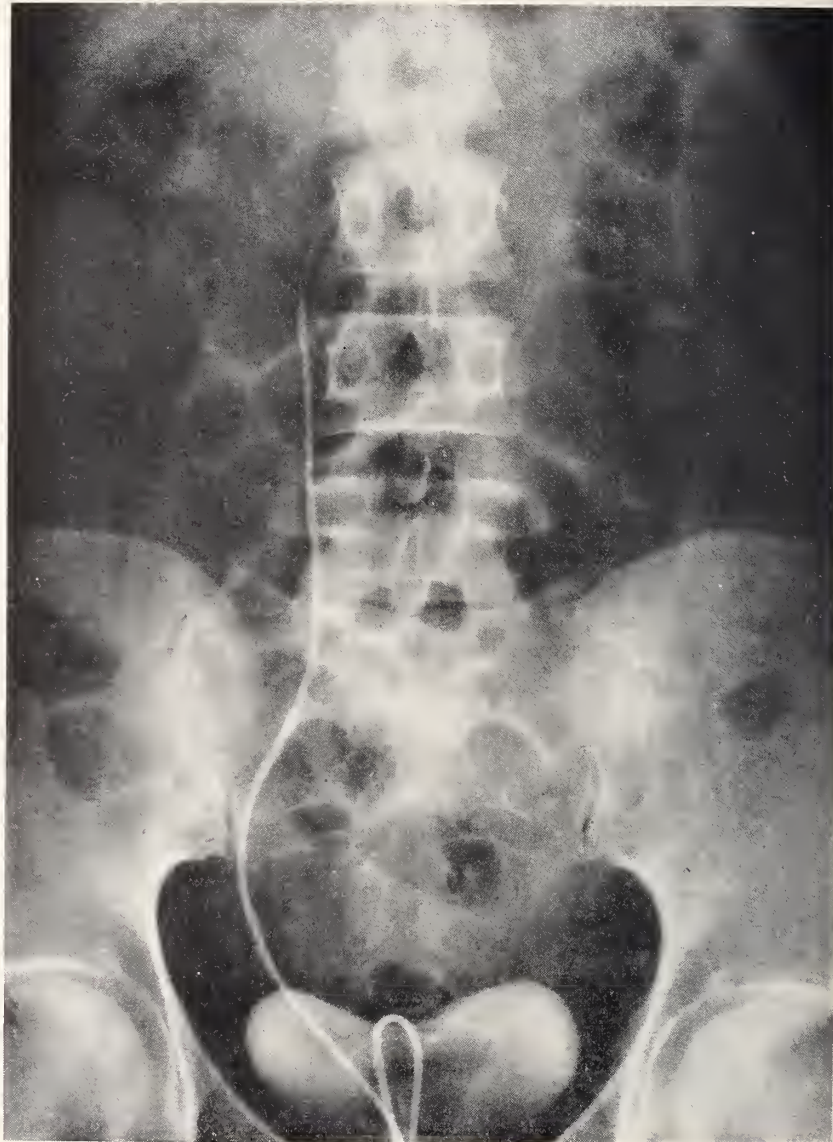


Fig. 1.

A renal angiogram was performed for evaluation.

What's your diagnosis?

(Answer on page 219)

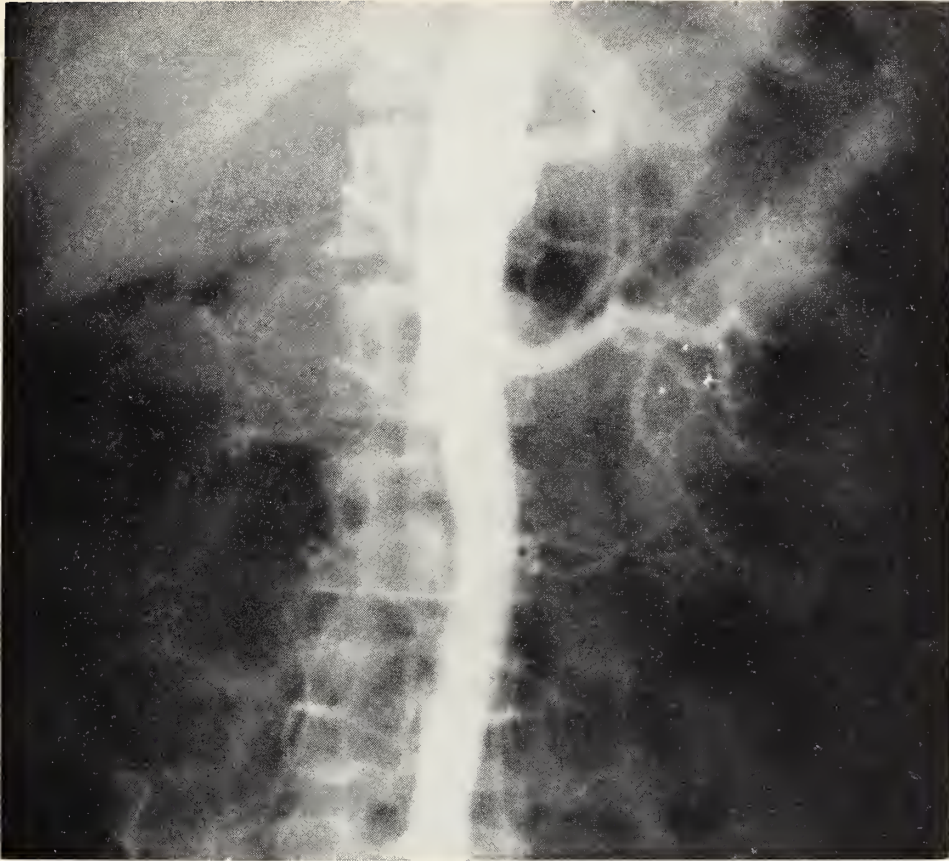
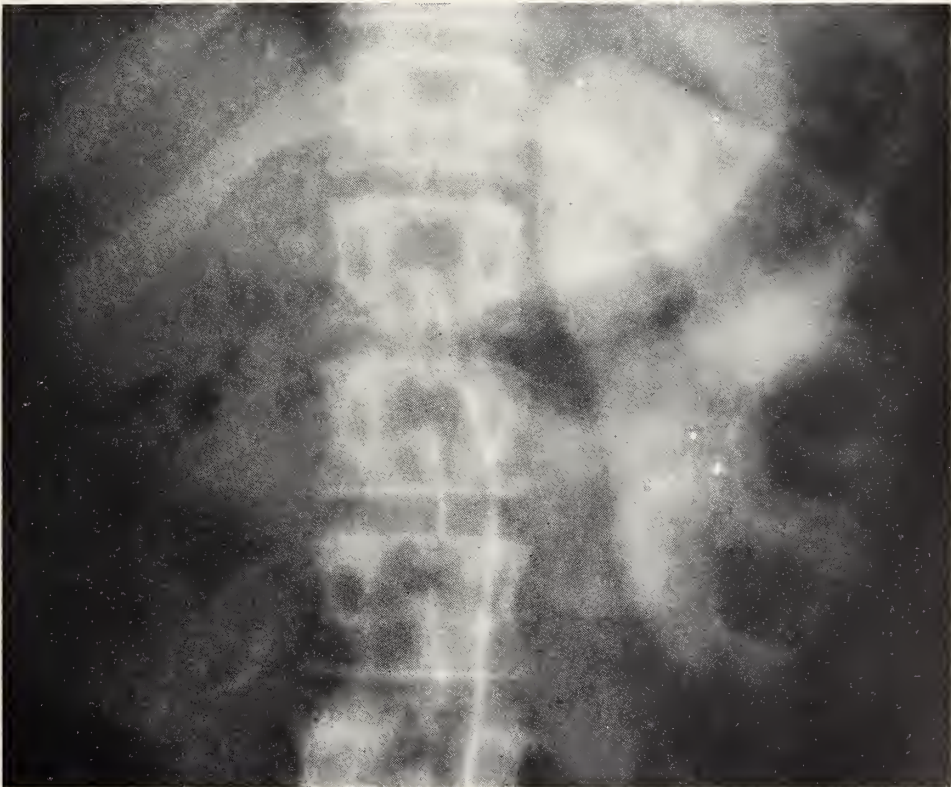


Fig. 2.

Fig. 3.



Illinois Department Of Public Aid**Payment Procedures and Policies Explained**

HAROLD O. SWANK, DIRECTOR
ILLINOIS DEPARTMENT OF PUBLIC AID

Part IV of a Series.

In last month's third installment of IDPA payment procedures, a medical billing form was traced administratively beginning with the first encounter of the doctor and a recipient/patient, through the transfer of all required identification data from the patient's case identification card (CID) to the billing Form 132, the listing of proper coding of the medical procedures, and the mailing of the Form 132 to Springfield for processing and payment.

Question: What is the practice or goal of the Illinois Department of Public Aid in paying medical bills timewise after receiving them?

Answer: IDPA strives to pay all bills within 45 days. Bills which are errorless and legible—requiring no individual consideration—move along at a faster rate and usually are paid well within the 45 days used as a yardstick for routine payment.

Bills requiring individual consideration—either because of error or a complicated medical procedure—move less rapidly and some may require more than 45 days.

The payment interval should not be judged in the context of processing one

bill which alone could be processed, if errorless, in minutes. Rather, one should consider that a single bill moves along the processing line accompanied by some 600,000 other medical bills in the course of a month's time. Of the 600,000, about 130,000 are physicians' bills. Five machine runs—each at an interval of about four working days—are required to handle physicians' bills alone.

Question: Do medical bills go directly to the computer?

Answer: No bill goes directly to the computer. All receive clerical scrutiny, many receive individual consideration by medically qualified persons, and very complicated procedures receive the considered judgment of professional consultants. A carefully prepared bill requiring only routine processing goes through 13 separate administrative procedures before payment is made. Bills rejected for error and bills receiving individual consultative consideration must go through additional procedures. But at no time does a bill lie about in a dormant stage awaiting action. Bills are moved in and out of the 13 way stations according to a fixed, taut schedule.

During the last seven days, the bills are in the hands of the Department of Finance and the Office of the State Auditor for payment. Thus, bills not in error or requiring other forms of individual handling will be processed and paid well within 45 days of the receipt of the bills in Springfield.

Question: How much delay is there on bills rejected by the computer or withdrawn for individual handling?

**DO YOU HAVE A
GROUSE**

concerning the
Illinois Department of Public Aid?
This is the place to air it.

Send to:

IDPA Editor
Illinois State Medical Society
360 N. Michigan Avenue
Chicago, Illinois 60601

Answer: The amount of delay varies with the degree of difficulty in correcting the error. A telephone call to a doctor may correct a minor inaccuracy, or staff making the initial clerical review may detect the absence of a required entry which can be corrected with minimum delay. Bills with improper identification—particularly those in which the patient appears to be ineligible—require a more meticulous search of the Soundex files (back-ups to the magnetic tapes) or a referral to the appropriate county department of public aid. Thus, while a minor error may cause scarcely any delay, a major error may delay payment of perhaps five weeks or more. The average delay is probably three weeks. However, since bills are processed by schedule, delayed bills must re-enter the processing schedule anew.

Question: In the clerical review do office clerks pass judgment on medical procedures?

Answer: No. Clerical or administrative review is quite different. When medical bills arrive in Springfield, the daily input is reviewed for visually apparent errors. The most obvious visually detectable error is no entry in a box calling for essential identification data. This could be absence of the physician's AMA number, which is usually easily corrected. Or the patient's name may be missing, the correction of which takes longer. The clerical review is a preliminary overview to cull out bills obviously in error—so that the correction process can commence as quickly as possible rather than to wait for the computer to reject them in later stages of processing.

The review also serves another purpose. Some medical procedures are rather complicated, having numerous alternatives. These are selected out for the individual consideration of a medically competent staff member or a professional consultant. In short, the clerical review is not a slowing process—it is a speeding up process.

The clerical staff also sorts the bills as to kind and puts them into numbered batches.

Question: Then what happens?

Answer: The bills are then processed through the computer section where they are totaled individually and by batch. They are given a voucher number, which becomes the permanent identifying num-

ber, and are posted to a control ledger.

The bills then go to the key punch section where operators transfer all pertinent information from Form 132 to an IBM card, using language a computer can understand—in other words, a numerical code. All possible care is taken to minimize human error.

Key punching is a two-part activity. An operator punches the IBM card and then passes it to another operator who “re-types” the same information electronically on a verifier machine. The machine compares the two operations and if there is any disparity, the machine indicates the probable error. The error is usually typographical and is easily resolved.

Next the cards are edited and balanced, after which they are fed into the computer at the rate of about 800 per minute. The computer checks to see that all essential information is present and that all codings support the specific actions desired. The identifications on the bill are the means by which the computer “finds” the case profile stored in the memory tape so as to transact and record the new business. Similarly, the AMA number enables the computer to find the doctor's individual profile and post the actions and payments thereto.

Computer rejected bills are returned to the medical control unit for correction of errors or resolution. There is an eligibility edit of the new tapes to check all bills rejected as “patient ineligible.” The edit may either confirm that no such patient is recorded in the case profile, or evidence may suggest the possibility of the patient being eligible (birth date matches that of a person in the case membership) or that the reject was possibly due to the improper naming of the patient on the billing form (for instance, Bobby instead of Robert). All such “patient ineligible” rejects are thoroughly checked out at primary source levels. Such interruptions are, of course, time-consuming.

Bills are then re-capped to show the amount of each procedural charge and the amount actually to be paid to the physician. Also, the total of the bill is indicated.

Question: How can the doctor tell what is happening to an unpaid bill?

Answer: For one thing, the recap going back to the doctor shows which bills are

unpaid by the words "delayed in processing, do not rebill." It is important that the doctor heed this instruction to avoid duplicate payment. The unpaid bill will not be forgotten. It will be either corrected and payment made or rejected as ineligible for repayment, always as quickly as possible.

Should the doctor re-bill the following month, he may be paid again—temporarily, once on the original delayed billing and once on the re-submittal. When this happens the Department must be repaid the amount of each over-payment and this is unnecessarily time-consuming both to the Department and to the physician.

However, this situation is becoming more rare as the computer now is being programmed to detect duplicate billings and to reject the second one.

Fully processed bills, in the form of computer print-outs, go to the Department of Finance for authentication of payments to be made in the form of warrants (checks) by the Office of the State Auditor. Checks are mailed directly to individual doctors.

Question: Are many errors made on Form 132 by physicians in coding and describing the medical procedures performed?

Answer: The number is sizeable and each ties up medical staff in the resolution process. Also, improper coding or an inadequate description of a medical procedure can result in incorrect payment or in the downward revision of the fee. Perhaps a listing of some recently noted procedural errors would be helpful.

One physician coded the *excision of a ganglion cyst of the foot* as 5351, which is "neurorrhaphy or suture of nerve, peripheral." The correct code should have been 1550—excision of ganglion cyst.

Another coded an *incision and drainage of left wrist* as 2996. This is the code for adenoidectomy.

In another instance, the excision of an *interdigital neuroma* was coded 1060, which is "excision, cartilage, joint." The correct code should have been 5271.

A *repair of diastasis, recti muscles*, was coded 4484. This is the code for "repair of posterior vaginal wall" (rectocele).

One physician did a *radical bunionec-*

tomy and coded it 3399. Procedure 3399 is for "excision perianal skin tag, or biopsy, anus." The correct code for the bunion operation should have been 1160.

Another physician removed a *cyst of the right temple area* and coded it 5154. This code is for "excision, lesion, intracranial or cerebral." The proper code should have been 0178—excision of subcutaneous skin lesion.

Among other errors in coding requiring individual consideration were the listing of the excision of a *sebaceous cyst of the scalp* as 5719, which is "biopsy, eyelid" and the resection of a *bronchial cleft cyst* as 2609, which is "exploration, spleen."

Question: Isn't payment allowed for a surgical assistant at a major operation? Whenever this is included on my Form 132 for a surgical procedure it is always deleted.

Answer: Yes—such fees are allowable. However, the surgical assistant must submit his own bill for this service, giving the patient's name, date, diagnosis, service rendered and the length of time of the surgery.

Question: What are some examples of unreasonable or excessive charges for medical procedures?

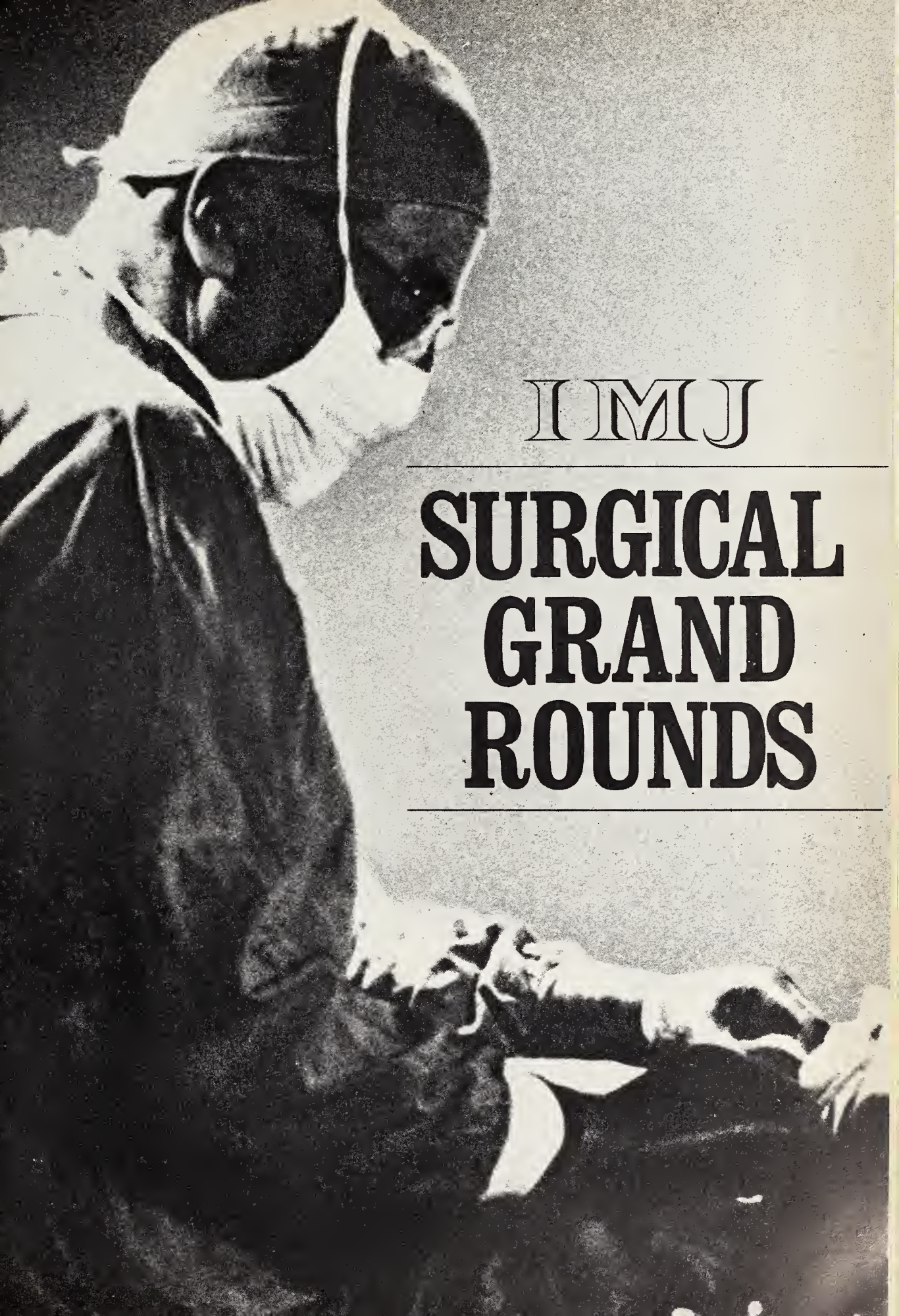
Answer: There are many. The following serve as examples.

One physician charged for a proctoscopic examination and for a sigmoidoscopic examination on the same patient on the same day.

Another physician charged for a cholecystectomy and appendectomy, a D&C, and for the excision of a right Bartholin gland—all on the same patient on the same day. His bill showed a full charge on each procedure. There are many cases of a similar nature in the latter example. It is the policy of the Department that when multiple surgical procedures are performed through the same incision, payment is to be made for the major procedure only, unless unusual circumstances exist and are fully explained in an operative report.

In another instance, a physician billed the Department for several hundred dollars for *emergency room and hospital follow-up care of a stab wound of the temple*, coding it 9071, but giving no additional

(Continued on page 218)



UMJ

SURGICAL GRAND ROUNDS

Surgical Grand Rounds are held weekly on Saturday at 8:00 A.M.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on May 18, 1968.

Traumatic Rupture Of the Duodenum

Case Presentation:

Dr. Thomas Kornmesser: This 49 year old truck driver was well until the day of admission when his truck was hit from behind. He was pinned between the steering wheel and a pile of boxes. The patient immediately experienced a minimal amount of abdominal pain, which gradually increased until he was in a great amount of abdominal distress when he came to Wesley's Emergency Room four hours later. When he was examined he was afebrile; pulse 120, blood pressure 220/120. Positive physical findings were limited to the abdomen, which was rigid, very tender, and bowel sounds were absent. Urinalysis: unremarkable. White blood count was 18,900, hematocrit 42 per cent and hemoglobin 13.9 Gm. Plain films of the abdomen were obtained. He was taken from the Radiology Department to the operating room. At this time he complained of shoulder pain.

Dr. Hirsch Handmaker: An upright chest film obtained on admission appears normal with no evidence of an intraperitoneal perforation (Fig. 1). There is no free air beneath either hemidiaphragm. Abdominal films, however, demonstrate a quite unusual finding, that of retroperitoneal emphysema. There is air collection along the right psoas border, extending from the infraheptic area perirenally, and then down into the pelvis (Fig. 2). There

is no similar finding on the left side. Though this appearance is rare, it is characteristic of the pattern that is described with perforation of the second and third portions of the duodenum, secondary to trauma to the abdomen. This fits well with this patient's clinical history, and the diagnosis is thus fairly secure. The other major cause for retroperitoneal emphysema is traumatic perforation of the retroperitoneal portion of the colon, which usually produces findings of air along the left psoas area, and is also usually associated with abdominal trauma. One patient was seen at Northwestern this year with retroperitoneal emphysema that arose when he was irrigating a colostomy and inadvertently perforated it with the catheter.

Dr. Robert Geurkink: The patient's description of the injury was interesting. He related that at the time of impact he felt and heard a "pop" inside of his abdomen. This describes what most authors believe is the mechanism of this injury. When a blunt force is applied to the upper abdomen the pylorus and the ligament of Treitz may be effectively blocked off and a closed loop in the duodenum produced. Thus, the fluid and gas filled duodenal loop is compressed by the external force, the internal pressure raised, and indeed bursts. At the time of operation we found

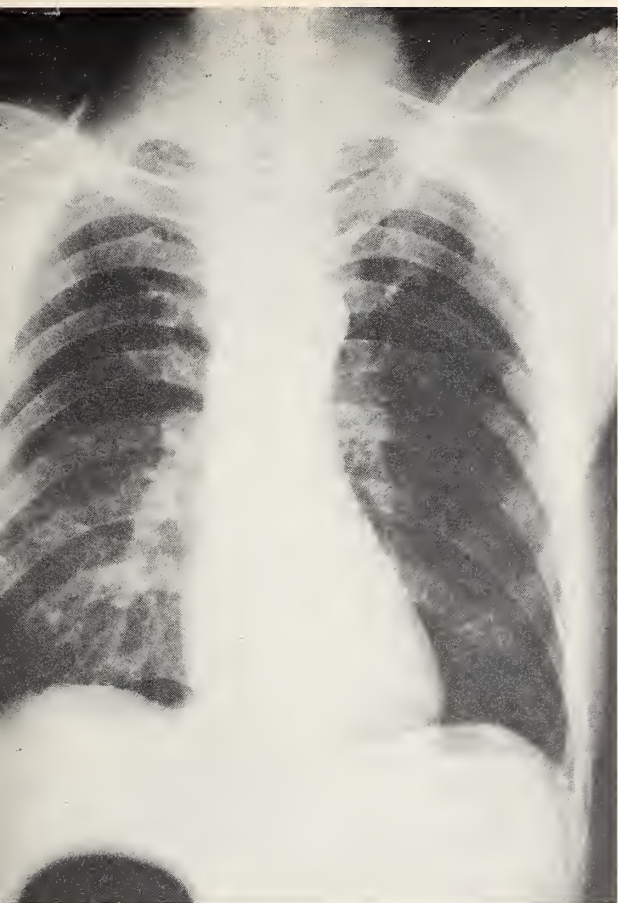


FIG. 1: Upright chest film with normal lung fields and no free air beneath either hemidiaphragm. Stomach bubble is seen below left leaf.

that he had almost completely transected his duodenum in the third portion (Fig. 3). His gall bladder was adherent and covered the second portion of the duodenum and an almost completely transected duodenum was found at this point. A small bridge of tissue was left. The edges were debrided and an end-to-end anastomosis was accomplished. About two-thirds of the injuries to the retroperitoneal portion will occur from the periaampullary area to the mesenteric vessel. In addition to the reconstruction a suction drain was placed in the infrahepatic fossa.

Waddell and Cleveland gathered 37 cases of retroperitoneal duodenal tear from the Denver area. They reported a 16% mortality for this injury. Of interest, those that died were operated upon more than 24 hours after the initial trauma. The plea for early diagnosis and early operation was made by these authors. They compared their series to earlier series. Cohn had 52 cases and a 20% mortality. In earlier series some recorded a mortality as high as

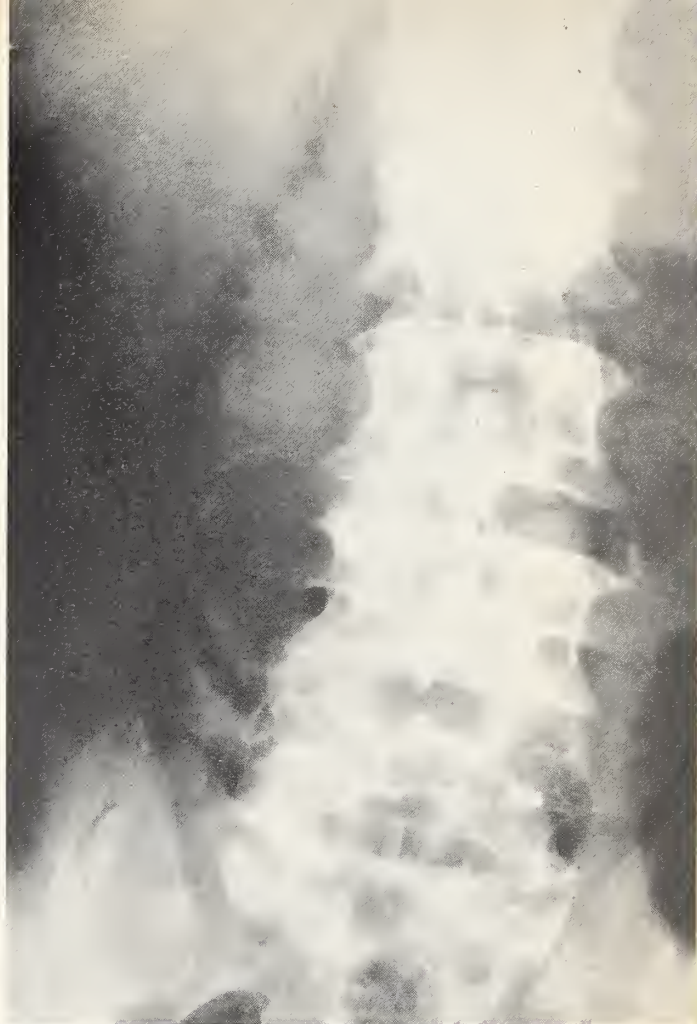


FIG. 2: Abdominal film demonstrating the collection of air along the right psoas border, under the liver edge, and into the pelvis. Suspicious air collection in area of transverse mesocolon as well.

92%, but included a number of patients not operated upon but found at autopsy to have retroperitoneal duodenal tears.

The diagnosis is not difficult in most instances. In this case gas was seen retroperitoneally. How much is seen depends on how large the tear is and how much leakage has occurred. Some of these cases go undetected for long periods of time because only small amounts of gas escape. Ultimately the gas outlines the duodenum and the kidney and the psoas shadow is obliterated. The majority have upper abdominal pain and some have vomiting. This man had intense abdominal pain. In Waddell's series almost all of them at some time had either shoulder pain or testicular pain, depending upon which way the fluid ran. This man was kept in a supine position and the fluid dissected superiorly, irritating the crus of the diaphragm giving him shoulder pain. If the gas and the fluid

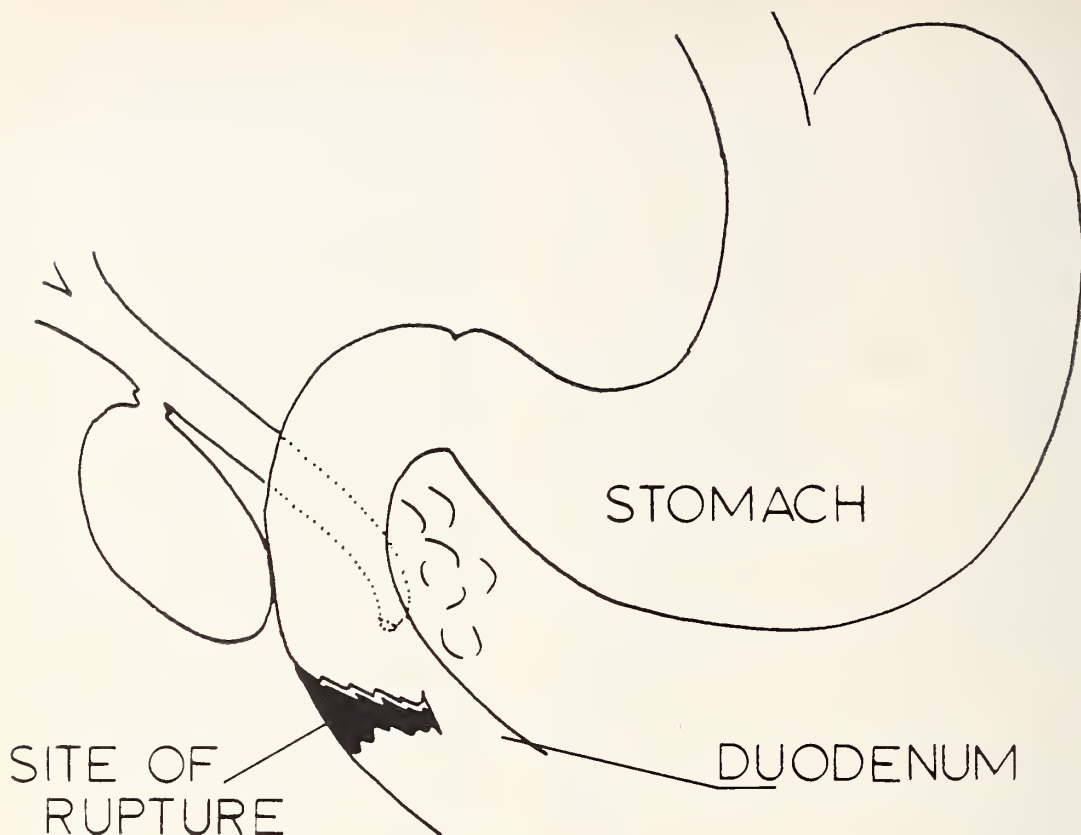


FIG. 3: Drawing indicates site of rupture of duodenum.

infiltrate to the kidney and the ureter, groin and testicular pain may develop. As far as treatment is concerned, the situation found dictates the procedure. Most of the tears may be simply debrided and closed. An occasional one, like ours, requires an end-to-end anastomosis. Several of Waddell's had to have reconstruction with a loop of jejunum because of extensive tissue loss. A plea, again, for drainage was made. Several of his patients that had died had not had external drainage. We put two suction drains in this man and he indeed drained copious amounts. Fourteen per cent of Waddell's series developed post-operative duodenal fistulas but presented no problem as long as there was a drain in place. They all closed spontaneously. Associated pancreatic contusions have been noted, and the excessive drainage from that source must be drained. One must explore both limbs of the duodenum and in order to do that you must mobilize the proximal limb of the duodenum. This is done also to see if the head of the pancreas is intact. Postoperatively our patient drained

copious amounts by nasogastric suction. From his suction drains he drained as much as 350 or 400 cc of drainage for the first three or four days. Such volume requires careful replacement. The drains were left in for about ten days in our patient.

Dr. John Beal: What was the nature of the drainage from the suction tubes?

Dr. Guerkink: At first it was greenish because of bile staining at the time of injury. After about two days it looked like serum. However, it was checked for amylase content and none was found.

Dr. Samuel Fogelson: Did you consider performing an arteriogram on this patient?

Dr. Guerkink: No. His physical findings and x-ray findings led us to the diagnosis of retroperitoneal duodenal perforation and immediately laparotomy was performed.

Reference

1. Cleveland, H. C. and Waddell, W. R.: Retroperitoneal rupture of the duodenum due to non-penetrating trauma. *Surg. Clin. N. Am.* 43:413, 1963.

Medical Progress

Psychosomatic Aspects of Headache

BY SEYMOUR DIAMOND, M.D./CHICAGO

Freud, in one of his lectures, took out a cigar and lit it. He then told his audience, referring to the stogie, "This may be a phallus but, gentlemen, let us remember, it is also a cigar. Symbolism is rampant in our psychiatrically oriented society."

Our method of fighting in Viet Nam is called anal-sadistic—a man in an airplane is in a non-organic environment, defecating on the organic world below by dropping bombs. (How far fetched!) Batman and Robin are denounced by psychiatrists as a pair of latent homosexuals. Nearly everything is straight, narrow, rounded or curved. To apply genital meanings to all of them is ridiculous. So often the problems of life are not the inner conflicts of a person but the defenses that he has set up against them. Family relationships, occupations, friends and marriages are basically stable factors in our life. The ability to talk out problems with one's physician may be of far greater help than any vivid portrayal or emotional re-enactment and/or catharsis as fondly depicted by television writers. It can alter the pattern of life and one's defenses. Treatment by listening may be all that is necessary in many cases.

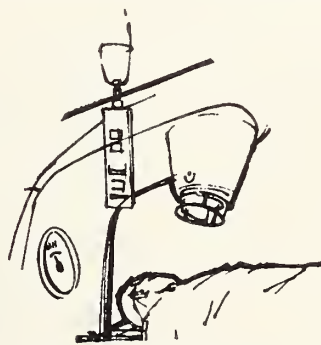
One cannot discuss the psychiatric aspects of headache without discussing the psychiatric aspects of pain in general. They all have a common psychophysiological mechanism. Man considers the head of

prime importance to his body. It is the origin of his thinking, his everyday living processes; it is the primary sensory input of hearing, sight, smell and the center for food intake. Voice and expression are the primary means of communicating with others. It therefore becomes one of the choice sites for the occurrence of psychogenic pain.

Classification of Headache

Headache is frequently classified into three large categories: (1) the vascular headache, which includes migraine, cluster, hypertensive and toxic headaches; (2) the

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HARVEY KRAVITZ, M.D.
Medical Progress Editor

muscle contraction or tension headache; (3) the traction and inflammatory headache which is usually caused by some organic lesion of the brain nerves or arteries of the head.¹

About 90% of all headaches encountered in office practice are benign. They involve psychologic or psychophysiologic factors rather than permanent structural change or serious illness.

The physician who sees a headache patient for the first time should do a careful physical and neurological examination as well as the indicated laboratory tests. Refer immediately only those cases that show definite evidence of organic disease. If you suspect that it is of a psychiatric nature, be cautious about early referral. One must always keep in mind that once a patient is referred to the specialist he may be subjected to sinus washings, extensive x-rays, spinal tap, angiograms and pneumoencephalograms. Some of the above procedures may produce a worse headache than he had before. It will also serve in many instances to fix in the patient's mind the fact that he may have an organic disease. This can hinder his improvement from his psychiatric headache.

I consider most tension headaches seen in practice as either a manifestation of a primary anxiety neurosis with conversion or a somatization of depression, or a mixture of both.

Psychological Factors

The person with frequent headache or head pain without organic causes is utilizing body language to express his personal and inter-personal conflicts. To quote Garner, "the psychological factors for headache may be predisposing, precipitating or

perpetuating and although the actual situations in the predisposition, precipitation or perpetuation may be quite dissimilar from person to person, the underlying emotional state is most frequently related to hostility. The nature of the headache likewise seems to vary and to be dependent on whether the psychophysiological effects are produced by muscular tensions, vascular alterations, or both. The dynamic factors are dependent on how the person perceives the interpersonal experiences which are so interpreted as to produce frustration, resentment, intense hostility and rage. Hysterical, obsessive, compulsive, dependent, schizoid, paranoid and cyclothymic personalities all view provocation, defense or action against provocation, and arousal of hostility, in different lights. Accordingly, tension headache, migraine, histamine cephalgia or Horton's type headache may be the characteristic mode of responding, depending on these factors."²

According to Shulman, the symptom, as a communication theory says, is that a psychophysiologic or conversion symptom is a meta-communication and symbolic body language in which the subject for various psychological reasons sends messages which he himself does not completely understand and which are equally often misunderstood by the recipient. The emotional reaction to the message may be rage, resentment, boredom, apprehension or other emotional states, and an element of anger always seems present; sometimes the most prominent emotion is fear or apprehension rather than anger, but then it is usually apprehension of being frustrated, or humiliated, or put in a situation in which one could suffer. The common symptom of headache fits such body language very well and it is one of the dynamic explanations used by the psychiatrist to understand the function of the symptom.³

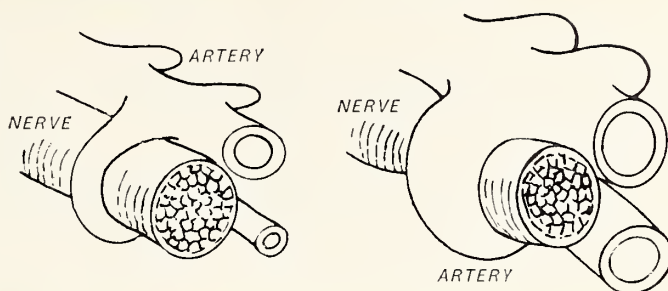
We don't want to eliminate all headaches. How many boys would be going out with girls they didn't want to go out with and girls with boys they didn't want to go out with if we didn't have headaches? Any practitioner of medicine can testify about the numerous female patients who avoid sexual relationships with the excuse of a headache. The "I don't feel well" headache is self-taught in order for the patient to remove himself, or herself, from an un-

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nervous tension → state of hypertonicity (vasoconstriction) → hypotonicity (vasodilatation)

Vasoconstrictive phase of vascular headache.
Vasodilatory phase of vascular headache.



R. E. Ryan: Headache—Its Diagnosis and Treatment, 2nd Ed., 1957, page 28.

wanted experience. The patient receives substitute gratification by the sympathy and attention which is used to soothe them. The patient, as time goes on, gets increased re-enforcement to this syndrome because when they are well they are not treated as good as when they have their headache.

The accompanying drawing taken from Ryan's textbook on headache shows how nervous tension can cause headache:⁴

Cause: Psychogenic—constant or periodic emotional stress.

Mechanism: (1) Vascular—vasodilatation of cranial arteries (2) Muscular—spasm of the skeletal muscles of the head and upper cervical region.

Depression Headache

Depressive headaches occur at regular intervals in relation to daily life, that is, on weekends, Sundays, holidays, and on the first days of vacations or after school or business examinations. They are capricious, bizarre, and follow no definite pattern as to location, although the occipital portion of the skull is frequently affected. Their duration is sometimes helpful in identifying them. A depressed person will describe his headache as lasting for years or all of his life. Associated symptoms that will be described later make the diagnosis of a depressive syndrome. A depression headache is usually dull and generalized, characteristically worse in the morning than in the evening. This diurnal variation is the most useful diagnostic characteristic of the headache and has occasioned a correct diagnosis of severe depression when other features have been inconspicuous. The fact that this headache does not re-

spond to the usual effective pain-relieving drugs helps in the diagnosis. Headaches associated with depression occur most often between 4:00-8:00 a.m. and 4:00-8:00 p.m. These periods are usually associated with what one calls a silent family crisis. It may be the time of the morning when the depressed patient awakens, and his fantasies of warfare with the members of his family, or his work conflicts, are manifested. In discussion with the depressed patient we find that his headaches occur when he leaves the quiet atmosphere of the office for a weekend at home. It often coincides with restful interpersonal situations in which the sufferer feels compelled to appear comfortable, relaxed, and agreeable although he is struggling to repress his resentment towards someone he is expected to love and respect.⁵

Migraine

Quoting Kennedy in 1933: "in broad terms the migraine headache represents a collapse of a way of dealing with life situations which are stressful to the individual. Up to a certain point the patient is able to cope with the accumulating tension and hostility resulting from the stress which he faces. Beyond this he cannot continue and there ensues a period of disabling pain during which he is forced to halt."⁶

The vascular system plays a major part in the protective patterns of the various body systems. In the nose, a vascular reaction helps shut out fumes and certain conflicts in life; in the bowel, vascular reaction attempts to rid the body of real or symbolic threats; in the head, vascular changes separate the patient from his intol-

erable environment.

In the family environment of most migraine patients the emotions of anger or rage have been suppressed. They are often first children who are pushed to perform and produce beyond their capacities. This merely heightens their feeling of inadequacy and frustration. Many migrainous patients live and re-live these early failures. Headache patients as a whole tend to build for themselves lives with too many environmental demands. They are extremely sensitive to this overload. They suffer situational anxieties in addition to those caused by deeper unconscious conflicts. Stress situations of life, such as menopause, puberty, change of school, change of job, paralyze their adapting mechanisms. Many psychiatrists have described this repressed hostility in the headache patient. A number of migraine sufferers come in not only for treatment of headache but also for concurrent chronic and recurrent depressions.

Very rarely do people who deal with headache emphasize the fact that a woman's migrainous headaches are the least of her troubles. I remember well a woman who angrily said to me, "Doctor, will you stop talking about my headaches and discuss my overall illness, my tendency to fatigue, my inability to keep up with my husband and my inability to keep the appointments I make?"

Tension Headache and Organic Disease

Neurotic patients who suffer from organic diseases may develop psychophysiological symptoms that are not directly connected with the primary pathology. These are due mainly to psychogenic reactions to the original organic disorder. Tension headache may often be a symptom of a psychogenic overlay in a case where headaches are caused by a minimal organic disorder. Often the headache is exaggerated when the organic disease has been unduly prolonged. Sometimes it may continue even after the organic cause is cleared up. The attitude of the physician, whether he be a general practitioner, internist, neurologist or psychiatrist, is most important in the treatment of the psychogenic headache. The fact that the physician is thoughtful, concerned and attentive lends confidence to the patient. He will, therefore, be more receptive to

treatment. The physician, of course, should take a careful, detailed history. This should encompass a careful inventory of his marriage, occupation, life stresses, personality traits, habits and methods of handling tension.

Taking Inventory

A very excellent example of going through this careful inventory is a headache patient referred to me by a gynecologist. In carefully going over an inventory of her life situation, I discovered that this beautiful young lady, recently married, was having a sexual difficulty. During the act of sexual intercourse her husband would interrupt the act prior to its completion and go into the bathroom and complete the act by masturbating in front of a picture of a nude female. Well, this certainly was upsetting to this young wife. The fact that she was able to ventilate the experience to me was of help in relieving her headaches. I don't know if we solved her marriage situation but to this date, which has been over a year, she is still married to this man. The fact that she had someone who would listen to her problem was of great help.

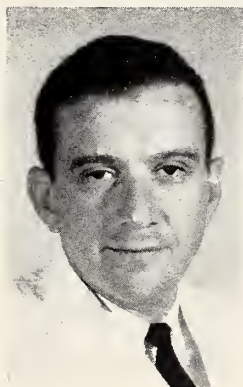
Go slowly! To uncover a patient's secrets too rapidly in interviewing is like knocking the support from beneath him, and may permanently cripple him. The patient must recognize his treatment situation and the fact that he needs to accept his life situation. He thus develops insight, particularly emotional insight, which in turn may give him some inward motivation to change his patterns of behavior. The physician should not make his patient dependent upon him and thus become a substitute parent for the patient. He should encourage in the patient emotional insight, and relief of his compulsive restraints and attitudes of rigidity. Emotional tension is greatly relieved by the opportunity to talk over, to converse, with an interested person. This alone is usually sufficient to alleviate the headaches in some. However, when headaches worsen after talking to the doctor, it is often a sign of success too. This is a sort of desensitization process. It means that the physician is succeeding in bringing out the hostile feelings and strong emotions.

(Continued on page 212)

A Clinical Study of a Hypersensitivity Pneumonitis

BY JORDAN N. FINK, M.D./MILWAUKEE, WIS.

A pneumonitis developing in certain pigeon breeders after inhalation exposure to pigeons has recently been described in this country and abroad. The illness is characterized by the development of chills, fever, cough, dyspnea, and malaise occurring four to six hours after exposure, and the presence of high titers of precipitating antibodies to pigeon proteins in the sera of affected individuals. Controlled exposure of the breeders to pigeons is followed by the clinical features of an acute attack. These features indicate that pigeon breeders' disease belongs to that group of hypersensitivity pneumonitides such as farmers' lung, bagassosis, and maple bark strippers' disease occurring as a result of sensitivity to inhaled organic dusts.



Jordan Norman Fink, M.D., is assistant professor of Medicine, Marquette School of Medicine, and chief of the allergy section, Milwaukee V.A. Center. He received his M.D. from the University of Wisconsin and served an internship at Mt. Sinai Hospital, Milwaukee and a residency at Milwaukee County Hospital. He has taken advanced study at Northwestern University. This paper was originally presented at the 1968 Convention of the Illinois State Medical Society.

Over the past several years we have been able to follow a group of twelve patients with pigeon breeders' disease in an attempt to characterize the clinical, pathologic, and immunologic features of this illness.

The ages of the breeders ranged from 34 to 60 years and all had from 1 to 40 years of daily exposure to from 100 to 500 birds. There was no correlation between the number of birds kept, or the duration of exposure to the onset of symptoms. Most breeders eventually became aware of a relationship of their symptoms to pigeons but not one gave up his hobby.

Our observations suggested that pigeon breeders' disease could occur in three major forms: acute, subacute, and chronic.

The acute form of pigeon breeders' disease is the most common form of the disease and was seen in the majority of breeders studied. The symptoms of chills, fever, cough, dyspnea, malaise and myalgia begin four to six hours after exposure to pigeons and lasted up to 12 or 16 hours, depending on the intensity of exposure and sensitivity of the breeder. Physical examination of the ill breeder reveals only fever to 103°F., overt dyspnea and bibasilar rales.

The chest film may be normal or may show coarse bronchovascular markings, fine sharp nodulations, reticulation throughout the lung fields and at times, coalescence of patchy densities.

Pulmonary function tests most often demonstrate restriction accompanied by a diffusion defect. Occasionally obstruction to air flow may be prominent.

Abnormal laboratory findings include a leukocytosis up to 20,000 with a left shift and at times eosinophilia. Gamma globulin levels have been elevated in 50% of the cases.

Most of the breeders demonstrated the immediate wheal and flare reaction after intradermal challenge with pigeon serum. Four hours after this reaction all breeders developed an area of induration and erythema at the injected site which resembled the Arthus phenomenon. Only residual reactions were visible by 24 hours.

Sera from all breeders contained high titers of precipitating antibody against antigens present in pigeon serum, pigeon droppings and other pigeon materials. These reactions varied from breeder to breeder with the most intense reactions found in those individuals with hypergammaglobulinemia.

Lung tissue obtained from an ill breeder revealed a mild interstitial pneumonitis. Small numbers of noncaseating granulomas resembling sarcoid were also present. Characteristic of this disease were the presence of clusters of foamy histiocytes surrounded by lymphocytes and plasma cells.

Controlled exposure of the sensitive breeder to pigeons or pigeon materials will reproduce all of the clinical and laboratory features of the illness. Avoidance of contact with pigeons, however, is associated with resolution of the abnormal clinical and laboratory findings, a reduction in the degree of skin reactivity, and a diminution of precipitin titers.

The subacute form of pigeon breeders' disease was found in a few breeders, and appeared to be associated with more constant exposure to the birds. Acute episodes were less frequent unless exposure was heavy. These breeders experienced persistent malaise, anorexia and a weight loss. Respiratory symptoms, when present, were of a bronchitic nature with cough and purulent sputum.

They also had laboratory, x-ray and pulmonary function abnormalities similar to those of the breeders with the acute form. High titers of precipitins could also be found, and intradermal challenge with pigeon antigens resulted in induration and erythema maximum at four to six hours.

Again, avoidance of contact was followed by relief of symptoms and reversion of laboratory, x-ray, pulmonary function and

immunologic features to normal.

One breeder who had prolonged contact with large numbers of birds for many years presented as a chronic form of the disease. This breeder did not have any of the acute episodes as seen in the other breeders, but complained only of progressive and severe dyspnea. The chest x-ray of this breeder was normal but pulmonary functions revealed a high-grade, only partially reversible, obstruction to air flow. Precipitins and skin reactivity was present as in the other breeders but avoidance of contact with birds or therapy with corticosteroids did not alter the clinical or laboratory abnormalities.

Lung tissue from this breeder revealed a severe obstructive bronchiolitis, and scattered granulomas. The foam cells, characteristic of the acute form, were not as prominent.

This breeder continues to have moderate dyspnea associated with obstructive lung disease in spite of avoidance.

Observations that the clinical manifestations of pigeon breeders' disease can be reproduced by exposure of sensitive breeders to pigeon materials and the presence of high titers of precipitins to pigeon antigens suggests that a hypersensitivity reaction plays a role in this disease.

Hypersensitivity pneumonitides following the inhalation of organic dusts have been known for many years. One of the earliest descriptions is that of farmers' lung. The signs and symptoms of this illness may be reproduced by inhalation challenge with moldy hay. The serum of affected farmers contains precipitating antibodies against moldy hay. Recent evidence has suggested that the antigens responsible for farmers' lung are derived from thermophilic fungi found in moldy hay.

Other illnesses of this group include bagassosis, found in workers handling bales of dried sugar cane, and maple bark strippers' disease, found in workers who strip the bark of maple logs. Thus, there is increasing awareness that occupations associated with the inhalation of organic dusts may be accompanied by the development of a hypersensitivity pneumonitis. This would suggest that occupational histories may be important in the diagnosis of these illnesses.

The history, physical, and laboratory findings are usually sufficient to suggest a

diagnosis of pigeon breeders' disease. The presence of precipitating antibodies to pigeon materials may support the diagnosis. These precipitin reactions, however, should be evaluated in conjunction with the clinical findings since sera from many apparently healthy breeders also react in a similar fashion.

The recurrence of symptoms with exposure to pigeon materials and the relief with avoidance indicates that the management of this disease should be complete avoidance. Corticosteroids may be useful to resolve the acute attacks or to lessen the signs and symptoms of the subacute form, but they appear to be of no value in the

chronic form of pigeon breeders' disease.

The pathogenesis of the hypersensitivity pneumonitides associated with organic dusts has not been entirely clarified. The latent period between exposure and the onset of symptoms, the delay in skin reactivity to intradermal challenge with pigeon antigens, and the presence of precipitins in the sera of affected individuals are compatible with an Arthus-like reaction of vasculitis and thrombosis. The appearance of the pulmonary lesions, however, resembles more the delayed or tuberculin-type of hypersensitivity. Thus, further studies are necessary to define the immunologic mechanisms responsible for this hypersensitivity pneumonitis.

Immune Mechanism Suppression Technique Developed

A medical research team at the University of Chicago's Pritzker School of Medicine has developed a technique to specifically suppress the body's immune mechanism. The technique may have far-reaching implications in organ transplantation.

It can prevent the body from rejecting a transplanted organ, while preserving the immune reaction responsible for fighting infections.

The technique is the culmination of eight years of research supported by the National Institutes of Health. The basic work on mechanisms regulating the immune response was carried out by Dr. Donald A. Rowley, Associate Professor of Pathology, Dr. Frank W. Fitch, Professor of Pathology, and pathology graduate students.

Animals respond to foreign material or antigen in two ways: by manufacturing antibodies, which are protein molecules in the blood, and by producing a new kind of white blood cell. Different antibodies or white blood cells are produced in response to each antigen and these react only with their antigen.

Antibodies are responsible for protection against most infections. The white blood cell response, however, can also attack transplants. A transplant, in fact, causes both responses, but only the white blood cell type results in rejection of a transplanted organ.

Transplants are now successful in man because powerful drugs are used to suppress the immune response. The drugs, however, suppress not only the response to the transplants but also responses to all other antigens. Consequently, patients with transplanted organs are extremely vulnerable to many kinds of infections.

The new technique developed at The Pritzker School of Medicine of The University of Chicago has the advantage of specifically suppressing the cell type response to the transplant without affecting the reaction to other antigens.

If the treatment can be adapted to use in man, the long-term survival of patients receiving such transplants as kidney, heart, or lung may be achieved without the use of potentially dangerous drugs.

Blindness Due To

Steroid Induced Glaucoma

BY MARCEL FRENKEL, M.D./CHICAGO

The glaucoma-provocative effect of steroid preparations instilled locally into the eye has been formalized by Becker¹⁻³ and by Armaly^{4,5} and their associates. This effect was first observed clinically in patients who had used steroids for considerable periods of time, principally topically and has been employed as a test for the confirmation of glaucoma in suspect cases and the detection of ocular hypertension in relatives of glaucoma victims.⁶

The purpose of this report is to present an unfortunate and essentially preventable instance of blindness most likely due to the protracted and unsupervised use of steroid preparations. It further underlines the dangers of self medication by a physician.

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Case Report

A 38-year-old resident physician was referred for ophthalmic consultation because of a gradual decrease in vision. The patient had been a moderate myope since adolescence, but had noted diminution in vision over the past several months with reduction in peripheral perception. He related that he had instilled dexamethasone ophthalmic ointment two to three times daily for the last three years to control an "allergic" conjunctivitis. The patient had consulted an ophthalmologist some 18 months previously, at which time a change in lenses was prescribed. There was no family history of glaucoma. The past medical history was otherwise unremarkable.

Ocular examination revealed vision to be 20/50 on the right and hand motions on the left with best correction. A mild ciliary injection of both eyes was apparent. Marked corneal edema, present bilaterally, was more pronounced on the left. The anterior chambers were deep. The irides were normal. The direct pupillary light reaction on the left was reduced but active on stimulation of the fellow eye. The direct pupillary response on the right was active. The vitreous and lens were clear bilaterally. Early glaucomatous cupping was observed in the right disc which had a myopic configuration. A very pronounced degree of glaucomatous optic atrophy was noted on

the left. The retinal markings and vessels were normal. The ocular tensions were 50 mm. Hg with the Schiotz tonometer. Gonioscopy demonstrated both chamber angles to be open to the level of the ciliary body.

Treatment with pilocarpine 2% q.i.d., eserine 0.25% h.s. and diamox 250 mg. every six hours normalized the intraocular pressure to 16 mm. Hg bilaterally with clearing of corneal edema. Later a normotensive level could be maintained with pilocarpine and eserine alone. With resolution of the corneal edema, vision on the right improved to 20/20 but remained at hand motions on the left. Central visual field examination (Fig. 1) with a 3 mm. test object on the right at 1 meter demonstrated a marked, yet irregular field loss.

Discussion

In 1954, Francois⁷ first described steroid-induced glaucoma in a 35-year-old patient who had received topical cortisone for three years in the treatment of vernal conjunctivitis. A glaucomatous excavation of the optic nerve head was noted. Cessation of cortisone therapy reduced the pressure to normal values spontaneously in one eye, while the other eye required surgery. Thereafter, a number of other authors have substantiated this clinical observation. Less frequent and less well documented is the observed increase in ocular tension during the use of oral or parenteral steroid preparations in the treatment of systemic conditions.⁸⁻¹⁴ While some authors have re-

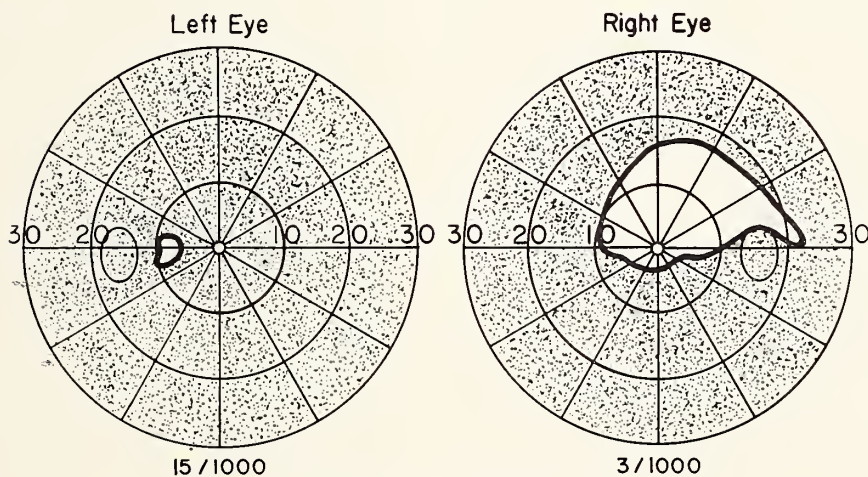


Fig. 1. Central visual field. Right eye tested with a 3 mm. white test target at 1 meter. Left eye tested with a 15 mm. white test target at 1 meter.

The visual field on the left was nearly completely obliterated with a paracentral island of vision only maintained with a 15 mm. test object at one meter. A trial at discontinuation of pilocarpine and eserine was associated with a renewed ocular hypertension. The patient has been continued on miotic therapy for 12 months with maintenance of normal tensions and stabilization of the visual acuity and fields.

ported such an effect, others have failed to note an increase in ocular tensions in patients who had received such systemic steroid treatment for many years for a variety of diseases.¹⁵ Bernstein and Schwartz¹⁶ demonstrated an increase in applanation pressure and a decrease in outflow facility in patients with rheumatoid and collagen diseases treated with systemic steroids.

Chandler¹⁷ noted that ocular tension may rise under systemic cortisone treatment

in some cases of chronic simple glaucoma. This item is not settled as authorities such as Goldmann¹⁸ have observed patients who have even applied cortisone ointment daily for several years without any resultant increase in intraocular pressure while Becker and Mills² have shown a striking and significant rise in ocular tension in the majority of patients with chronic simple glaucoma to whom they administered topical betamethasone for short periods. Furthermore, these authors demonstrated that 30% of a normal volunteer group showed significant pressure elevation and decreased aqueous outflow facility on topical dexamethasone.

The marked penetration of topical steroids into ocular tissues and the possible effect of these drugs upon ocular aqueous dynamics contrast with the apparent ineffectiveness of short term systemic steroid administration to influence such dynamics. In previous experiments¹⁹ we have studied the possible effects of the administration of large pharmacologic doses of desoxycorticosterone acetate intramuscularly and aldosterone intravenously in patients with known chronic open-angle glaucoma. These mineralocorticoids were chosen because of their well known influence on salt and water metabolism, both inducing a retention of sodium and a kaliuresis. Essentially no effect upon the intraocular pressure or aqueous dynamics was observed despite massive systemic doses and an appreciable alteration in urinary sodium and potassium excretion. It was felt that homeostatic mechanisms were mobilized in response to the systemic hormonal effects in such a manner that no net alteration in metabolic exchange resulted at the ocular level. Thus, the topical action of steroids on aqueous dynamics possibly relates to the high penetration and the high concentration which is effective at the ocular cellular level.

The biochemical mechanism whereby the glucocorticoid hormones exert their glaucomatogenic effect is unknown. Woods²⁰ considered that corticosteroids might induce a retention of sodium intraocularly. Should this mechanism be operative, Francois²¹ feels that known glaucomatous patients with hypercorticism should manifest increased intraocular pressure. However, steroid action may be manifest only in eyes whose ocular mechanism is already

compromised by a metabolic abnormality which is then exacerbated by the hormonal effects. There may also be an abnormal substance present in the trabeculum of glaucomatous individuals which may be influenced by steroids, possibly by hydration in such a manner as to block the outflow channels and increase the resistance to the evacuation of aqueous. Becker and associates²² demonstrated gammaglobulins in the trabeculum of eyes afflicted by open-angle glaucoma. The nature of this protein material and its role, if any, in glaucoma is not yet elucidated. Francois²¹ suggested that the action of hyaluronidase might be inhibited by steroids with a resultant accumulation of hyaluronic acid within the trabecular meshwork. Hyaluronidase, *in vitro*, facilitates the evacuation of aqueous while corticoids have been shown to inactivate hyaluronidase. It is of interest to consider that diurnal variations in intraocular pressure and in plasma 17-hydroxycorticoids have been found to follow a parallel rhythm^{23,24}.

When topical steroids have been used to unmask glaucoma in relatives of patients with known glaucoma, visual field changes have as a rule been reversible. The ocular hypertension may become apparent as early as seven days and more predictably within three to eight weeks of instillation of dexamethasone, betamethasone, prednisolone or triamcinolone with a return to normotensive levels following discontinuation of the test drugs. Goldmann has observed that some patients with steroid induced glaucoma do not manifest typical glaucomatous visual field changes and show optic atrophy only late in their course. Other observations by Becker and associates²⁵ revealed that some glaucomatous patients with preexisting field loss showed a reversible increase in their scotomata when the intraocular pressure was raised after the instillation of betamethasone.

Along another line Becker and co-workers²⁶ have sought to demonstrate a hereditary pattern to the hypertensive ocular response to steroids.

In a recent development, Dorsch & Thygeson²⁷ indicated that a newly introduced steroid, Medrysone has potent antiinflammatory activity, yet has been found, in a small series of patients, to be free of glau-

comatogenic activity. This compound is a structural analogue of progesterone which itself has been thought to have some effect in lowering ocular tension^{28,29}

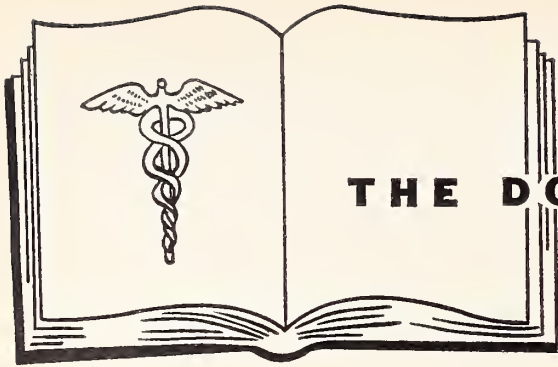
Summary

The unfortunate instance of the prolonged topical use of dexamethasone by a young physician in the treatment of a chronic conjunctivitis is reported. Self-medication was continued for a three year period without ophthalmic supervision. This situation exemplifies the dangers of self-medication and underlines the caution

with which topical steroids must be prescribed. It is likely that a substantial number of persons become psychologically habituated to the use of these drugs to control minor inflammatory ocular disturbances and apply them for considerable periods without adequate medical control. The probability exists that our patient had been predisposed to glaucoma and the steroids simply precipitated a latent situation. Current thoughts on postulated mechanisms of steroid-induced glaucoma are reviewed.

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THE DOCTOR'S LIBRARY

THE MANAGEMENT OF TRAUMA. By Members of the Staff of Johns Hopkins University School of Medicine and the Johns Hopkins Hospital, Baltimore.

The importance of a text which deals solely with the injured patient is best appreciated by the fact that trauma is the third leading cause of death in this country. With this outstanding book the members of the staff of Johns Hopkins School of Medicine and the Johns Hopkins Hospital have made an important contribution to medical literature.

In the first chapter the authors outline the precise steps and the order in which they must be taken in the evaluation and resuscitation of the critically injured patient, thereby setting the tone of the entire volume. For the most significant aspect of this book, and the feature which distinguishes it from other surgical texts, is the constant and repeated emphasis placed on the special problems in pathophysiology, diagnosis and treatment of the injured patient.

In succeeding chapters devoted to injuries of various organ systems, the current methods of diagnosis and management are discussed. However, each contributing author stresses rapid and accurate diagnosis of life threatening conditions and outlines the immediate steps which must be taken before a more sophisticated examination can be accomplished.

For example, in the chapter on thoracic injuries the authors list the causes of ventilatory insufficiency in the patient with a chest injury. Rather than follow with a long description of the physical findings in each, leaving the reader to devise his own means of diagnosis, they present an approach for examining the patient with a critical chest injury by which the examiner can rapidly diagnose cardiorespiratory

embarrassment, and at the same time differentiate its cause.

Excellent discussions of the current concepts of wound healing, shock, cardiac and respiratory resuscitation, and the medical problems which may complicate the management of the injured patient are also included.

This comprehensive book will obviously be of greatest value to the physician in the emergency room, or the surgeon who is called upon to give definitive treatment to the injured patient. However, with the increasing number of accidents in this country it behoves every physician to be aware of the information which is so clearly and concisely presented in this new book.

Stuart M. Poticha, M.D.

PATHOLOGY OF INFANCY AND CHILDHOOD. John M. Kissane, M.D. and Margaret G. Smith, M.D., C. V. Mosby, St. Louis, 1967. 1082 pages, 703 illustrations, \$39.50.

This book on pediatric pathology is based on the large amount of carefully studied pathological material available at Washington University School of Medicine and Barnes Hospital in St. Louis. It begins with two chapters on general pathology, one on growth and metabolism and one on infectious diseases. The remaining twelve chapters are organized like those of a standard textbook of systemic pathology.

The pathology of infancy and childhood is covered from the point of view of the general pathologist, with emphasis on clinical aspects as well as on pathogenesis, prognosis and response to treatment. Special technics of anatomical pathology useful in children are detailed where applicable.

The book is clearly written and abundantly illustrated. The illustrations are well selected and of the high quality we have come to expect from Washington Univer-

sity. Appropriate electron photomicrographs are used when needed, and have been selected so as to be easy to interpret, even for the general pathologist. The references are numerous and up to date.

There are one or two places where the book could be improved. The section on acquired diseases of the kidney is a little less authoritative than some of the other chapters; for instance, one does not get a clear picture of membranous glomerulonephritis. Perhaps this is because needle biopsy of the kidney is not often done in children. The chapter on peripheral nerve and muscle is brief and should be expanded, even though the book already weighs almost 3 Kg. It is true that these conditions are adequately covered in most pathology texts, and it is possible that it is unfair to expect a specialized text to give the same type of coverage.

This book should be of interest not only to the general pathologist, but also to anyone interested in pediatrics. It is comprehensive enough to serve as a reference work, and it seems reasonable to think that it may turn out to serve as one of the basic reference books in pediatric pathology.

JOSEPH C. SHERRICK, M.D.

NEUROPSYCHIATRY IN WORLD WAR II, Volume I (Zone of Interior). Col. Albert G. Glass, M.C., USA (Ret.) and Lt. Col. Robert G. Bernucci, M.C., USA (Ret.) Government Printing Office, Washington, D.C. 826 pages, 67 illustrations, 16 charts, 67 tables.

During the early days of mobilization for World War II, it was widely believed by responsible professional and military authorities that psychiatric disorders would occur only in so-called weaker individuals who were already predisposed to such illness. For that reason, a major effort was made to exclude these individuals from

military service by screening at the induction level. It was believed that this procedure would prevent or at least diminish serious psychiatric problems, and that the main function of psychiatrists in the Army would be to detect and screen out the men who had escaped detection at the induction station.

As the war progressed, however, it became increasingly clear that this reliance upon selection and elimination had failed to prevent the appearance of large numbers of psychiatric cases. Further, battle experiences clearly demonstrated that combat psychiatric breakdown could originate from normal or previously stable personnel, as well as from those of greater vulnerability. The Army Medical Department was thus confronted with the difficult task of dealing with an unprecedented incidence of psychiatric casualties for which there had been little preparation. The struggle to overcome these handicaps and the eventful establishment of effective programs of prevention and treatment present an epic achievement in military medicine. The editors of this volume have included a summary chapter, "Lessons Learned," making available in compact form the essentials of the hard-won knowledge gained by military psychiatry in World War II.

The immeasurable gains made by military psychiatry in World War II had a direct bearing on the explosive expansion of civilian psychiatry after the war. The exigencies of war fostered the concept and practice of the earliest possible treatment of emotional disorders, as near as possible to the site of origin. And the success of these wartime techniques was a stepping stone to the current nationwide movement for the establishment of community mental health centers.

T. R. VAN DELLEN, M.D.

Illinois added 199 new plants and 388 major expansions to its industrial growth in 1967. These plant investments amounted to \$630 million and will create 42,601 new jobs in the future. Since 1961, 3,961 new and expanded plants were announced creating 145,156 new jobs and plant investments of \$2.3 billion.

Regional Medical Program

For Heart Disease, Cancer and Stroke

BY WRIGHT ADAMS, M.D./CHICAGO

Improvement of health care for patients with heart disease, cancer, stroke, and related diseases is the principal aim of the Illinois Regional Medical Program. One of the 54 Regional Medical Programs across the nation, it seeks to bring the very best in diagnosis and treatment of heart disease, cancer, stroke and related diseases within the reach of every physician, other health professional, and health institution in the Illinois Region. The Program focuses on helping the patient by enhancing the ability of the health professional.

Tremendous amounts of money have for some time now been flowing into medical science research. As a result, knowledge is now available which could improve a patient's chances for survival, particularly for those persons suffering from heart disease, cancer or stroke.

These three killer diseases continue to account for approximately 70 per cent of the deaths in Illinois and throughout the

United States each year. Yet many of these deaths can be prevented.

Recognizing this, Congress in late 1965 passed Public Law 89-239, the bill establishing Regional Medical Programs. The philosophy behind Regional Medical Programs is to minimize the lag between science and service. The need for a more concerted approach to the prevention, diagnosis and treatment of heart disease, cancer and stroke has been established. Conscientious physicians apply most such research as soon as the results are proved. Yet this quick application is not universal. Regional Medical Programs want to see this knowledge from research translated into practice. They want to give health professionals, organizations and institutions the capacity to implement various programs of improved care and diagnosis for the named diseases.

Under the terms of the establishing legislation, the Program hopes to accomplish this end without interfering with present patterns and methods of financing professional practice and hospital administration.

National legislation recently extended Regional Medical Programs through June 30, 1971. In doing this, Congress said that it would like to consider the Program a permanent one, but did also want to be able to review it after a few more years.

Grants Provide Mechanism

Regional Medical Programs function through a grants mechanism. Such grants, according to the law, are "to encourage and assist in the establishment of regional cooperative arrangements among medical



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served there as associate dean and chief of staff of its hospital and clinics.

schools, research institutions, and hospitals for research and training (including continuing education) and for related demonstrations of patient care in the fields of heart disease, cancer, stroke and related diseases." Individual physicians, in cooperation with a larger institution, can develop proposals for grant support. The law stipulates that all RMP activities be done "in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies."

A key feature of Regional Medical Programs then is the concept of "regional cooperative arrangements." Regional Medical Programs are based on voluntary cooperation among the various health-related organizations, institutions, and professionals in a region.

"Regional cooperative arrangements" has seemed a somewhat difficult concept to grasp. In practice it refers to a working together or coordination on a local level of various health professionals towards the achievement of a particular goal.

Regional Medical Programs hope to foster such coordination or cooperation on local levels because they see these relationships as conducive to the best quality patient care.

IRMP Involves Many

In a region the size and complexity of Illinois, the involvement of representatives of the affected health professions, organizations and institutions requires a good deal of cooperation. When the Program was first developing, the Coordinating Committee, which is composed of the deans of the five Illinois medical schools and the College of Osteopathy and the heads of their designated major teaching hospitals, met with the leadership of the Illinois State Medical Society, the Chicago Medical Society, the Illinois Hospital Association, the Illinois Department of Public Health, and the Hospital Planning Council for Metropolitan Chicago, among others.

Out of these meetings and discussions a plan was developed which established the State of Illinois as the planning area for a Regional Medical Program. The original planning grant was awarded July 1, 1967.

Today these groups, as well as such organizations as the Illinois Division of the

American Cancer Society, the Chicago and Illinois Heart Associations, the Illinois State Dental Society, the Illinois Nurses Association, and others continue their involvement with the Program.

The Division of Regional Medical Programs has the responsibility for the administration of the legislation, including the grants program established by it. Originally a part of the National Institutes of Health, this division is now a part of the newly created Health Services and Mental Health Administration within the Department of Health, Education, and Welfare.

At present some downstate areas of Illinois are receiving the attention of two RMP's. The Bi-State Program, centered in St. Louis, had Eastern Missouri and Southern Illinois as its preliminary planning area. As yet, no strict lines have been drawn.

The initial legislation makes no attempt to define the geographic boundaries of the many regions. In setting up the Illinois Program, it was felt that the state boundaries would constitute the best region, for certainly the Illinois Regional Medical Program's interest is statewide. In fact, in some areas this interest extends to other states. It is well-known that persons living in communities near the state borders do not allow these political lines to limit them as they seek health care. Interregional cooperation is a basic element of Regional Medical Programs, however, and a mechanism for assuring that all areas can participate in the Program.

As the Program evolves, it is recognized that expansion of the concept may proceed in either one of two ways: major regions centered in large metropolitan areas may well undergo a sub-regional development basing their apex upon smaller yet fully qualified areas in which all components specified in the law are available. These sub-regions would relate to the major regional organization and would develop autonomy in their operation to the extent that it is appropriate yet depending upon the basic region for some of the major highly specialized services.

In the ultimate development of delineating boundaries of the operational "regions" provisions are being made for the development of sub-regions based upon population centers and the surrounding functional

service area which could be properly identified and developed as fulfilling the definition of a "sub-region." Within Illinois more and more neighboring hospitals are beginning to organize into councils and also to share or pool their facilities and cooperate in other ways, all steps toward subregionalization. The Illinois RMP would like to encourage such activities.

Program Stresses Self-Determination

The emphasis in Regional Medical Programs is on self-assessment and optimum utilization of the health resources in a particular region. In Illinois this has involved a study of the number and distribution of physicians, dentists, nurses, other health professionals, hospitals and certain select facilities such as supervoltage radiation therapy equipment.

Regional Medical Programs do not want to duplicate existing programs. Rather, they seek to work through and strengthen such programs.

Although RMP's are a federally supported program, again it should be repeated that Regional Medical Programs are based on voluntary cooperation, rather than operating through a set governmental structure. The legislation establishing Regional Medical Programs provides no real federal blueprint. Instead, the challenge of developing a program is left to the individual regions.

Several steps are involved in this process. The National Guidelines outlines them as follows: 1) Involvement, 2) Identification of Needs and Opportunities, 3) Assessment of Resources, 4) Definition of Objectives, 5) Setting of Priorities, 6) Implementation, and 7) Evaluation.

Such steps apply on all levels from the local through the state region to the federal. The basic philosophy of this program holds that those persons most directly affected, and in many cases they are the practicing physicians themselves, are the ones who should determine the thrust of the Program.

The Illinois Regional Medical Program has developed six Task Forces, two categorical committees and subcommittees to assist the Coordinating Committee and the Advisory Committee, a group required by law for the Program, as they formulate goals for the Illinois region. These groups are also defining objectives and setting

priorities, two other essential steps for the Program.

Improved Care an Objective

The broad objectives for the Illinois RMP include the improvement of patient care through continuing education programs for physicians, nurses and all health personnel whose skills are essential to the operation of the regional arrangement; the development of better methods for the exchange of information among medical schools, medical centers, community hospitals, practicing physicians, and other health institutions, organizations, and personnel; and the expansion of plans for further improvement of patient care. The Illinois RMP is also interested in gaining information on regional population movements, prevailing health services and gaps in certain geographical areas or among age, ethnic or other groups.

Generally, then, the Program seeks to provide the framework in which the individual practitioner can have access to the best in knowledge, facilities, techniques and expertise.

Cooperation Has Priority

High on the list of priority factors for potential projects is the development of regional cooperative arrangements. Possibilities include medical schools, other professional schools, teaching hospitals, community hospitals, research establishments, universities and other educational institutions, public health agencies, voluntary health organizations and other public and voluntary agencies and organizations. Such cooperative arrangements constitute the keystone of the Regional Medical Program concept.

Service to persons less adequately served than others, including in particular the urban and rural poor, shall receive a high priority in assessing projects. Here in the ghettos and poverty pockets is where the science-service gap is most evident. Thus, attention here is most important.

Individual projects are judged by the Task Forces and Committees on the basis of whether they will indeed serve to strengthen regional cooperative arrangements and, by so doing, bringing about a series of functional relationships through which further advances in health care can be implemented. The intent of Public Law 89-239 and its extension, Public Law 90-

574, is to encourage initiative, individuality, and cooperation in the assessment of needs and resources, in program planning, and in the development of a system of high quality health services for the population.

Community-wide or region-wide benefits thus should be incorporated into projects, since this is a priority factor.

Projects aimed at maximizing utilization of manpower (particularly personnel and skills in short supply) and minimizing unnecessary duplication of expensive facilities and equipment will receive a high priority rating.

Continuing Education Important

Projects containing elements of continuing education, or testing innovation in the delivery of health care will all receive high priorities. Dr. Stanley Olson, national director of the Regional Medical Programs, has termed continuing education "the most significant single component of Regional Medical Program activity." Such efforts could be directed to the general public as well as to the health professionals.

Finally, the Illinois RMP encourages applicants to enlist other sources of funding as well as the IRMP.

Actual applicants for grants must be institutions or agencies which are public entities or non-profit corporations. Proof of such status is required. Individual physicians, as they develop an idea for an operational proposal involving cooperative arrangements generally have been successful in involving their community hospital, teaching institution or other non-profit group. Proprietary institutions are not eligible applicants but may participate in the operational project activity.

Diversity and innovation in the development and administration of operational projects is encouraged, but this must take place within the boundaries of the legislative authority, applicable general policies, and the necessary accountability for public funds. It is expected that policies and procedures will evolve with time and experience.

IRMP Planning Continues

At present the Illinois RMP is functioning in its second year of a planning grant. Actually, all 54 Regional Programs have planning grants which continue to be funded. Congress anticipates that this proc-

ess will continue as a normal part of the operation of each program since the purpose is to provide means for continuing improvements in the care of patients as medical science advances. Given the rapid advancements in medicine, planning will have to be a continuous process.

Although the Regional Medical Program Act was approved in 1965, it was not until fiscal year 1967 that the first operational grant applications were approved. By June of last year, 13 regions across the nation had received funds for operational projects, while a number of other regions had applications pending. The Illinois region has not yet "gone operational."

Although Illinois ranks fifth in population in the United States, this fact does not necessarily guarantee that it will receive a proportionate amount of the operational grant funds from the national division of Regional Medical Programs. Federal funds are given according to the merit of the individual proposal rather than according to some apportioning formula.

In fact, as funding becomes more limited due to federal spending cuts, regions will be judged competitively.

The Illinois RMP seeks to encourage the development of operational proposals for its region. The staff is available for consultation on project ideas. In addition, Task Force and Committee members scattered throughout the state could be approached for their opinions.

The initiative and decision-making have to come from the local communities and from its health leaders, however. The action takes place within and among our existing institutional and personnel resources. The Program seeks to be an instrument of synthesis among diverse elements, agencies, institutions and individuals.

It is not the objective of the Program to create another mechanism of funding individual intramural projects; rather, it seeks, through operational projects based on "regional cooperative arrangements," to bring the benefits of scientific advances in medical care to persons with heart disease, cancer, stroke, or related diseases.

It is then a program of both opportunity and challenge. It needs the active support and leadership of the medical profession if it is to be successful. ◀



ILLINOIS ASSOCIATION OF THE PROFESSIONS

A successful IAP annual meeting was held in October at the Ambassador East in Chicago. At that time, Franklin P. Lee, R.Ph., succeeded Phillip J. Kartheiser, D.D.S., as president. Other officers will be elected by the Board of Directors in January. In 1969 we plan to arrange a weekend annual meeting which will insure a maximum attendance and participation of members and their guests.

The American Association of the Professions is planning its initial meeting in February and information on this meeting and a trip to Spain has been mailed to all IAP members.

It is increasingly evident that professional people are being called upon and urged to use their knowledge and talents to help solve the problems of the community, state and nation. Your continued interest and support of the Illinois Association of the Professions with the combined efforts of the member organizations will help in these endeavors.

In 1968 membership in the Illinois Association of the Professions was increased by the addition of:

Illinois State Veterinary Medical Association	11
Illinois Pharmaceutical Association	37
Illinois Society of Professional Engineers	23
Illinois State Dental Society	3
Illinois State Bar Association	3
Illinois Council of the American Institute of Architects	5
Illinois State Medical Society	8

At the Annual Meeting held in October, the IAP Committee on Legislation and Governmental Agencies under the chairmanship of Walter E. Hanson, P.E., of Springfield discussed the following legislative matters of interprofessional interest:

There are bigger things in life than money. Bills, for instance.—Live Lines.

1. Endorsement of Con-Con
2. Endorsement of the billion dollar pollution bond issue
3. Broadening of the sales tax to professional services, including a report by the Illinois Taxpayers Federation
4. Recent conference with Speaker of the House, Ralph T. Smith
5. Procedures for joint action on legislation

Inauguratory session of the American Association of the Professions and plane trip to Spain is scheduled for February 22-March 2, 1969. The plenary session is to be held at the Detroit Metropolitan Airport Hotel on Saturday, February 22, at 2:00 p.m., followed by a dinner. An 8:00 p.m., departure by jet plane for an eight day trip to the Sun Coast of Spain will follow. The second session will convene in Spain. "All members of the Illinois Association of the Professions have an important role to play in decisions to be made at the Inauguratory Session of the AAP."



All members are billed for dues in January of each year.

Since our dues are at a minimum in comparison with other state associations, and our operation is comparable to the receipts—prompt payment establishes a basis for a sound fiscal year, and eliminates the concern and expense of soliciting renewals at a later date.

"INCREASING PROFESSIONAL PRODUCTIVITY"

BY EUGENE L. VICKERY, M.D./LENA

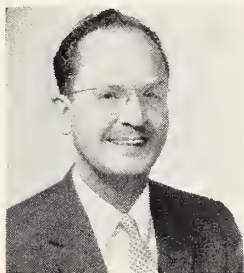
A title like this smacks of efficiency: so I should hasten to point out that I earn my living as a family doctor in a small town—a country doctor, in fact. A less efficient type of activity can scarcely be imagined. However, as the years have gone by I have had occasion to do a good deal of staff work in a growing hospital and have tried to observe and to learn the trends of modern practice.

The mechanical and electronic aids, some of which would seem little short of miraculous to my esteemed father, whose line or work I have followed, we will not particularly discuss. We will be concerned chiefly with the persons involved in the "health team." Professional productivity refers to the use of a professionally trained person's knowledge and skill. Increasing such productivity, then, means supplementing the professional person's activities with the supporting skills of technically trained individuals. These individuals are responsible to the professional for the technical excellence of their performance, but the professional person remains responsible to the patient or client for the excellence of the service, whether it be medical care, accounting, dental care, highway construction or what not.

In the medical field, the physician has traditionally felt responsible for health care and has tried to make use of whatever other trained people were available where he was working. Sometimes that meant

quickly telling the husband how to help at time of childbirth and sometimes it meant simply mentioning to the anesthetist that the patient's muscles were a little tight so that he or she would know to increase the relaxation. In the country, trained persons are fewer; so the doctor makes more of the moves himself. In the medical centers, the physician tends more and more to concentrate on thinking about what needs to be done and then giving the necessary orders for a technically trained person to do it. This is considered more efficient and professional productivity is increased because more patients can be cared for in a given length of time. Of course, some patients do not appreciate too much efficiency and long for the days when they could spend enough time with the doctor to be sure he understood their particular problems and was devoting his attention fully to them. In the medical field, at least, it is important not to let efficiency ride too rough-shod over personal feelings. Those who help the physician must be trained to maintain a kindly and interested attitude even though their work may be quite precise and mechanical.

Trained persons in the health field do not suddenly appear. Recruiting them from the high school graduates who are tempted in many directions is a formidable task. Occasionally an individual doctor may persuade someone to become a physician, pharmacist, nurse or technician, but for the most part this requires so much time, effort and materials that it would in itself seriously impair the physician's effectiveness. Consider that the health field in a wide sense needs about one out of every seven, or 14% of the high school graduates of this country. Think then of the number deflected by inability and lack of interest, by marriage, factory, business and farm. Think of the needs of other profes-



Eugene L. Vickery, M.D. is a Lena general practitioner. He received his M.D. from Northwestern University and is currently serving as vice-president of the Illinois Association of the Professions.

sions. Recruiting persons to be trained in medical professional, sub-professional, technical and maintenance fields then appears, as it is, an almost impossible proposition.

The medical profession depends a great deal upon the Woman's Auxiliary to interest and teach young people about the needs, the opportunities and the rewards of health careers. From national study and planning to the local sponsorship of health career clubs, the Woman's Auxiliary responds to this challenge. Medical organizations—the county, state and national medical societies, hospital associations, and the societies of the various trained individuals themselves—all are concerned with and work at the problem of persuading youth to join the health team. The Health Careers Council, supported by the various health team societies, is a leader in this field.

What specifically is offered in the way of training and reward? The individual doctor usually does not know for sure. The national chairman of the health careers committee of the Woman's Auxiliary to the AMA, Mrs. Wendell Roller of Monmouth, and her committee, have compiled a record of up-to-date information. This particular listing for the north central region covers about four dozen health careers. There are said to be about two hundred, but these are certainly the principal ones. From cytotechnologists to X-ray technologists there are listed here the places

in the 12-state region where training may be obtained, the preliminary education required, any available information about income to be expected, scholarships available to students and the names and addresses of state and national associations pertaining to the activity.

In order to increase professional productivity in medicine, young persons must be interested in health careers, must be trained, utilized and paid. Doctors in their offices employ a few, generally nurses, secretaries and laboratory or X-ray technicians. Hospitals, medical teaching centers, nursing homes, physiotherapy centers, pharmaceutical and laboratory facilities employ a great many more and the physician uses their skills directly or indirectly.

What the health team needs—whether a complex organ-transplant group or a country doctor using the willing extra hands of a non-plussed husband—is reflected in the needs of the other professions. Professional productivity can be vastly increased by the use of technically trained persons and technical aids. Only by using these supplements more extensively and more intensively can the needs of an expanding population for more professional service be met. The Association of Professions offers an ideal way for the professions represented to co-operate in the recruitment of young talent for all professional and sub-professional fields.

Rural Health

If each community or compact rural area had its own physician within a 15-to-30 minute driving distance, the anxieties in procuring medical care would be considerably diminished. But such sanguine eventualities are not apt to occur, at least within the next several years. The Sears-Roebuck Community Medical Assistance Plan, which helps both physicians and nonurban communities "get together" by providing guidance and technical know-how to rural area community leaders and establishes a certification of both the need for a doctor and the ability to support him, acknowledged this July that the demand for physicians is undeniably critical.

The Foundation's Medical Advisory Board stated: "The day that every small town can hope to have a resident physician is gone. The change in our country from a rural to urban society with corresponding population shifts has tolled the death knell to the hopes of many rural communities for a resident physician. The competition for the services of a physician is intense. Each city, small town, and even doctors vie for the services of available physicians." (Rural Health Manpower. **PR Doctor** (American Medical Assn.) (Sept./Oct.) 1968; pgs. 8-11.)

Observation on Erythema Nodosum

By BRUCE L. BROWN, M.D./URBANA

Red, tender, painful nodules on the anterior surfaces of the lower legs, rarely on the arms, and occurring predominately in females, have been recognized by physicians since Robert Willan¹ drew attention to them in 1808. Despite the ease of diagnosis, an assignment of cause in the individual case often remains difficult. A *Lancet* lead article of Feb., 1962, called attention to the fact that most large series include a high proportion of cases in which the cause is not established. Erythema nodosum has been described as an outstanding example of a non-specific inflammatory dermatosis triggered primarily by systemic bacterial and toxic agents.² In this presentation we deal with these etiological associations of erythema nodosum and with the experience with the syndrome at McKinley University Hospital since 1960.

Associations

Female Hormones

Early studies by Lofgren³ emphasized pregnancy and lactation as factors related to erythema nodosum. Erythema nodosum occurring in each of successive pregnancies in a woman without other apparent reason for the syndrome was such an instance in the author's experience. The high incidence of the syndrome in females in all series probably represents factors related to female sex hormones. Recent report of the association of erythema nodosum with the administration of the oral contraceptive agents, norethydral and mestranol⁴ is another example of hormonal factors being related to this entity.

Table I
Causes of Erythema Nodosum
From Textbooks.

Text	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
A	x	x	x		x	x					x	x		x		x	x	x	x	x		x	x	x	
B		x			x		x		x	x	x	x	x		x			x		x	x		x		x
C		x			x		x	x						x			x			x	x			x	
D					x		x	x	x		x	x		x			x		x	x				x	

1. Ascariasis
2. Cat scratch fever
3. Chancroid
4. Chickenpox
5. Coccidioidomycosis
6. Diphtheria
7. Drugs
8. Endocarditis
9. Gonococcal septicemia

10. Histoplasmosis
11. Leprosy
12. Lymphogranuloma venereum
13. Measles
14. Meningococcemia
15. Pertussis
16. Pharyngitis
17. Rheumatic fever

18. Sarcoid
19. Scarlet fever
20. Streptococcal infection
21. Syphilis
22. Tonsillitis
23. Trichophyton infection
24. Tuberculosis
25. Ulcerative colitis



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Presbyterian Hospital, New York. He also served internship and residency at the University Hospitals of Cleveland.

Rheumatic Fever

Because of the occasional associated arthralgias and fever, a relationship of erythema nodosum to rheumatic fever has been debated from Willan's time to the present. Three of four standard medical textbooks list rheumatic fever as a disease with which erythema nodosum is associated (Table I). Yet several authors categorically deny such a relationship. Keil⁵ stated in 1937 that he felt that the relationship of erythema nod-

osum to rheumatic fever should be investigated anew. His own observations did not appear to substantiate the hypothesis that erythema nodosum was of rheumatic origin even when preceded by a sore throat and followed by joint manifestations. Favour and Sosman⁶ in their excellent review of 155 cases in 1947, concurred, that despite the presence of a migratory polyarthritis at times, that erythema nodosum was not a form of rheumatic fever. White⁷ states that erythema nodosum, urticaria, and angioneurotic edema are relatively rare in rheumatic fever. Cobbs⁸ states that while erythema nodosum and erythema multi forme may both be later consequences of streptococcal infection, they have no intimate relation to rheumatic fever. Friedberg⁹ indicates that erythema nodosum has been reported as appearing in rheumatic fever but is a non-specific hypersensitivity reaction to a variety of agents. McCarty,¹⁰ on the other hand, feels that erythema nodosum is another skin disorder which appears to be a manifestation of the acute rheumatic process.

Confusion concerning the differentiation of subcutaneous rheumatic nodules and erythema nodosum could, in the author's opinion, be the reason for these differences of opinion. The size, the color, the location, and the presence or absence of tenderness should serve to distinguish one from the other.

Drugs

The drugs reported to bear an etiological relationship to erythema nodosum include bromides, iodides, salicylates, penicillin,

sulfonamides, particularly sulfathiazole,¹¹ phenacetin,² and the oral contraceptives.⁴ In our drug-taking culture, interrogation of the patient with erythema nodosum may help to disclose other agents which have a relationship to the syndrome.

McKinley Hospital Cases

Thirteen cases were reviewed from the McKinley University Hospital records from 1960 to the present. One patient had a firm etiological relationship to histoplasmosis. This patient had a rise in the yeast phase of the histoplasmin complement fixation test from 1:32 to 1:128 during the acute illness with a subsequent fall of 1:64 (Case 9, Table II).

This case was the only one in which a determination of the uric acid was made. Uric acid during the acute illness was 17.7 mgm %. A repeat test three months later showed a value of 5.5 mgm %. The description of the use of colchicine^{13,14} in the treatment of erythema nodosum made this observation interesting.

Four of the thirteen patients in this series had had an illness diagnosed as infectious mononucleosis in the months preceding the development of erythema nodosum. The high incidence of infectious mononucleosis among university students may render less significance to this observation. Nevertheless, it may be well to look for such an association in future cases.

ASO titers were done in ten of thirteen cases. The significance of a single measurement is doubtful even when moderately elevated. However, it does underscore the fact that most physicians place streptococ-

Table II
Cases at McKinley University Hospital

Case	Date	Age/ Sex	Throat Culture	Chest X-Ray	Sed Rate	ASO	EKG	Hist.	Tbc.	Coc.	Mono	Med.
1	4/ 6/60	26/F	Neg		53	50						
2	10/28/60	20/F			6	12			0		'60	
3	4/ 4/61	19/F			18	125						
4	6/28/61	13/F							0			
5	5/14/62	19/F	Neg	Neg	17	166	Normal					
6	9/26/62	28/M			25	50	Normal	+	0			
8	12/ 3/62	42/F			15	166						
8	11/17/64	30/F			45	125	Normal					
9	7/ 8/65	22/F	Neg	Neg	43		Normal	+	0			*
10	1/20/66	21/F	Neg		7	166					'65	
11	2/25/66	20/F		Neg	8		Normal		0		'65	
12	3/24/66	20/F	Neg	Neg	30	166		0	0			**
13	10/16/67	20/F		Neg	19	166	Normal	0	0		'67	

**Propylthiouracil

*Enovid

cal infections high on the list of agents with which erythema nodosum is associated.

Changes in the clinical spectrum of diseases occur. The etiological association of erythema nodosum which, at this time, appears to be non-specific to a number of agents, may change with time, with geography and with culture.

Study of the Individual Case

In the investigation of a case of erythema nodosum, the history and the physical examination should help to exclude most of the systemic illnesses with which it is associated (Table I). A search for drug factors may be rewarding. Laboratory investigation should include a chest x-ray for evidence of sarcoid or other pulmonary disease, the culture of sites suspected of harboring streptococci, skin tests for tuberculosis, histoplasmosis, and coccidioidomycosis. Studies to exclude rheumatic fever may be in order but the American literature suggests that this is not one of the diseases with which erythema nodosum is frequently associated. If the diagnosis is not apparent, continued observation may be the best consultant. Further observations of uric acid levels during erythema nodosum would be interesting.

Treatment

The treatment of erythema nodosum is the treatment of the disease with which it is associated. Bed rest in the absence of a disease such as rheumatic fever does not seem necessary. Antibiotics are not indicated in the absence of a clear reason for their use. Corticosteroids suppress manifestations of the syndrome and may be necessary but are not curative. A trial of colchicine may be warranted in the case with a high uric acid. Response to colchicine is probably non-specific in this non-specific entity.

Conclusions

1. Erythema nodosum, a syndrome rather than a disease, is easily recognized but continues to provide a problem in etiological diagnosis.
2. The syndrome is seen predominately in females and the recent reports of oral

contraceptive agents playing a role in the production of the picture re-emphasizes this fact.

3. The relation of erythema nodosum to rheumatic fever has been confusing in the past but at this time is probably not great, at least in the United States. The differentiation of erythema nodosum from the subcutaneous rheumatic nodule may be a reason for this difficulty.
4. Review of cases at McKinley University Hospital revealed that four of the thirteen cases had had an illness diagnosed as infectious mononucleosis in months immediately preceding development of erythema nodosum. This observation should be investigated further as it may show another etiological relationship of erythema nodosum.
5. A high uric acid value in a patient with erythema nodosum which appeared to be related to histoplasmosis was interesting in view of reports of colchicine being effective in the treatment of erythema.
6. Comments are made on the diagnosis and treatment of erythema nodosum.

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Clinics for Crippled Children Listed

Twenty-seven clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. There will be twenty-two general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social, and nursing service. There will be three special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Mar. 4—Carrollton—Boyd Memorial Hospital
- Mar. 4—Alton General—Alton Memorial Hospital
- Mar. 5—Hinsdale—Hinsdale Sanitarium
- Mar. 5—Carmi—Carmi Township Hospital
- Mar. 6—Peoria Cerebral Palsy (A.M.)—St. Francis Community Clinic Area
- Mar. 6—Sterling—Community General Hospital
- Mar. 6—Effingham General—St. Anthony Memorial Hospital
- Mar. 11—East St. Louis—Christian Welfare Hospital
- Mar. 11—Peoria General—Children's Hospital
- Mar. 12—Joliet—St. Joseph's Hospital
- Mar. 12—Champaign-Urbana — McKinley Hospital
- Mar. 13—Springfield General—St. John's Hospital
- Mar. 13—Sparta—First Baptist Church Edu-

cational Building

- Mar. 13—Macomb — McDonough District Hospital
- Mar. 14—Chicago Heights Cardiac — St. James Hospital
- Mar. 18—Belleville—St. Elizabeth's Hospital
- Mar. 19—Jacksonville—Norris Hospital
- Mar. 19—Evergreen Park—Little Company of Mary Hospital
- Mar. 20—Elmhurst Cardiac — Memorial Hospital of DuPage County
- Mar. 20—Decatur—Decatur Memorial Hospital
- Mar. 25—Danville—Lake View Hospital
- Mar. 25—Peoria General—Children's Hospital
- Mar. 26—Centralia—St. Mary's Hospital
- Mar. 26—Springfield Cerebral Palsy—Diocesan Center
- Mar. 26—Elgin—Sherman Hospital
- Mar. 26—Rockford—St. Anthony Hospital
- Mar. 28—Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

SMOKING AND LIFE EXPECTANCY

PRESENT AGE	PACK-A-DAY SMOKERS can expect to live to age	2-PACK-A-DAY SMOKERS can expect to live to age	NON-SMOKERS can expect to live to age
25	68.1	65.3	73.6
30	68.4	65.8	73.9
35	68.8	66.3	74.2
40	69.3	66.9	74.5
45	70.0	68.0	75.0
50	71.0	69.3	75.6
55	72.4	71.0	76.4
60	74.1	73.2	77.6
65	76.2	75.7	79.1

DATA:
American Cancer Society

Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.



Membership Forum

Members of the Illinois State Medical Society:

For many years the Illinois State Medical Society and the American Medical Association have enjoyed expert guidance and leadership in the many fields of professional medicine.

At the next meeting of the American Medical Association House of Delegates, Illinois will nominate Walter C. Bornemeier for the office of president elect, and Burtis E. Montgomery to succeed himself as a trustee on the Board, which he now serves as chairman.

The advice and consultation of scientifically trained men is sought both by the individual physician and by the professional associations to which he belongs. The opinions of these leaders are respected in the many areas associated with medicine today—scientific, socioeconomic, the field of public health, public affairs, etc.

The president-elect and the Board of Trustees of the A.M.A. provide much of this leadership at the national level. These Illinois physicians have proven themselves many times as the champions of medicine. Their records—one in the rural area of Southern Illinois and the other in the city of Chicago, have provided outstanding leadership through the years at the local, state and national level.

Illinois ranks high among the states in the field of professional training. Approximately 20% of the physicians in the United States have received all or part of their training in this State. Consequently, these two physicians have friends and associates all across this country.

The American Medical Association headquarters are located in Chicago; research projects are being conducted in the recently established A.M.A. biological sciences laboratory now associated with the University of Chicago; Illinois is truly in the "heartland" of medicine.

Illinois is privileged to nominate Walter C. Bornemeier and Burtis E. Montgomery for these two important positions.

William K. Ford, Chairman
Illinois Delegation to the AMA
H. Close Hesseltine, Secretary
Illinois Delegation to the AMA

Dear Sir:

As I write this letter, the 76th Illinois General Assembly is convening in Springfield. Accordingly, our legislators will soon begin discussing and voting upon a number of crucial issues that affect each and everyone of us, both as physicians and residents of Illinois.

One such issue which I feel particularly deserves our attention is the "implied consent bill" (Senate Bill 17) which has been proposed as an amendment to the "Uniform Act Regulating Traffic on Highways."

This bill proposes under the "implied consent" provision, that a driver agrees when he receives his driver's license, that if he is stopped, charged with a violation, and becomes a suspect of drunken driving he will submit to a breath test. The penalty for refusing such a test would be a six month license suspension.

Although I personally feel that the real heart of the bill was removed when the provision requiring the driver to submit to a blood alcohol test was deleted, I, nevertheless, also feel that this bill is worthy of our attention and support as professionals dedicated to the preservation of human life.

Figures from the National Safety Council show that in 1960, 38,137 people in this country lost their lives in automobile accidents; while in 1965, 49,163 people died on our nation's highways. Last year, 53,000 Americans were killed in auto accidents. Of these, 15,600 were between the "early driving and drinking ages" of 15-24. Authorities indicate that roughly one-half of these fatalities can be attributed to drunken driving.

Therefore, may I take the liberty to recommend that we, as physicians, each write our representatives in Springfield, expressing our support for this bill.

As medical research strives toward the preservation of human life, attempting daily to increase our fellowman's longevity, let us attempt to curb the slaughter on our highways in every way possible.

Sincerely,

Edwin A. Lee, M.D., Chrm.

ISMS Committee on Public Safety

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

With this listing are included those towns which have been added since the *Journal* began carrying lists of openings in early 1968. This will bring the readers up-to-date through the first half of the counties in Illinois. We will continue carrying these listings in the hope that the Illinois physician will help gain practitioners for places which are in need.

BUREAU COUNTY: Sheffield; population: 1,200. Trade area, 4,500. One physician, age 66. Nearest hospitals at Princeton and Kewanee, 17 miles, 15 miles; 50 miles from Peoria. Local pharmacy. New medical building available if desired. Financial assistance available. Churches: Congregational, Catholic and Methodist. Schools: grade; 4 miles to high school (bus service) 15 miles to Blackhawk Junior College. Golf course and swimming pool nearby. New Jones and Laughlin Steel Mill at nearby Hennepin. For further information contact: Rev. Arnold Schaper, Sheffield. Phone: 454-2290.

DEKALB COUNTY: DeKalb; population: 28,000. Trade area, 40,000. Forty-six physicians in county including 30 G.Ps. Three hospitals in county with 250 beds. Available space in well equipped medical building if desired. Laboratory, x-ray facilities and pharmacy. Agricultural and industrial area. Twenty churches. Grade and

high schools. Northern Illinois University located here. Only 18 of the 46 physicians are practicing in DeKalb: DeKalb Clinic, 11; DeKalb Medical Center, 7. Substantial guarantee or salary. For further information contact: James Ellis, M.D., DeKalb Medical Center. Phone: 815-758-3495.

DEKALB COUNTY: Somonauk; population: 1,000+. One hour from Chicago loop on Route #34. Last physician retired within last year after 60 years in practice. Hospital at Sandwich, 3 miles; 20 miles from Aurora, population 68,000. Prescription drug store. Financial assistance available. Agricultural area. Churches: Protestant & Catholic. Eighteen hole golf course, local swimming facilities. Plans made to expand 65 bed hospital to 100 beds. For further information contact: Duane Johnson, Somonauk. Phone: 815-498-2343.

FULTON COUNTY: Astoria; population: 1,200. Trade area, 8,000. One doctor age 62 practicing on limited basis. Modern attractive office available. Office building and equipment free up to \$25,000 net income per year. New factory employing 200. New high school. Seven churches. New 3 bedroom ranch style home being held for doctor. Previous doctor grossing \$35,000. If full time doctor found, present doctor is to leave. New 49 bed nursing home will be started in spring of 1969; 8 miles from Illinois river. Good recreational facilities. Hospitals in Havana and Rushville, 15 minutes. For further information contact: E. J. Bubb, President, Farmers State Bank, Astoria. Phone: 217-389-2223.

HANCOCK COUNTY: Plymouth; population: 800. One part time physician, urgent need for full time doctor. Nearest hospitals at Macomb and Carthage, 18 miles; Quincy, population: 50,000, 48 miles. New clinic building in 1960; large enough for two doctors. Sources of income: agriculture and industry. Churches: three Protestant. Country club, golf course, new bank. For further information contact: Robert G. Cox, Phone: 309-458-6487; Louie Lee Sutphen, R.N., Phone: 309-458-6508.

(Continued on page 220)

Ocular Trauma

By CHARLES V. BARRETT, M.D./EVANSTON

The subject of ocular trauma is important to all physicians, and it is well for us as oculists to review this subject occasionally.

Injuries to the eye are best divided into the following categories:

- I. Mechanical injuries to the globe.
- II. Burns to the globe and adnexae.
- III. Lid injuries
- IV. Injuries to the orbit.
- V. Endogenous toxicity to the globe and adnexae.

Mechanical injuries may cause permanent damage to the globe and consequent loss of vision. A blow may cause immediate perforation of the globe with prolapse of the intraocular contents, hemorrhage, cataract, retinal detachment, rupture of the choroid and avulsion of the optic nerve. It is important to realize that though the initial injury be minimal, blindness may result from such complications as intraocular infection, sympathetic ophthalmia, secondary glaucoma, retinal detachment, or intolerance to intraocular foreign bodies.

Let us then review mechanical ocular injuries more specifically under the following subdivisions: A) Conjunctival and intracorneal foreign bodies; B) Corneal abrasions; C) Contusions; D) Perforating injuries without retained foreign bodies; E) Intraocular foreign bodies.

In a patient presenting with an ocular foreign body it is imperative that an immediate personal history regarding the time, place and manner of injury be obtained before "compensationitis" sets in. The visual acuity, testing the injured eye first, must be found. A sterile topical anesthetic such as ophthaine must occasionally be used to allow the patient to open the injured eye to test vision. A magnifier, preferably a slitlamp, a good light source, and a treatment tray are necessary adjuncts. The upper lid must be routinely everted, but it is surprising how many physicians are unable to turn an upper lid. (This simple technique must be taught in medical school and during the internship.) Next, the globe should be examined for

staining, using fluorescein strips. These and only these should be used in order to avoid the contamination of the solution by organisms dangerous to the eye.

Having found a foreign body, the simplest method of removal is by irrigation with sterile saline. Also a sterile cotton stick applicator held gently to the foreign body may remove the offending agent. If these methods prove unavailing, then a spud or 27 gauge needle on an empty 2cc syringe for convenience of handling must be used under intense light and good magnification to undermine and lift out the foreign object. Iris freckles and posterior corneal pigment dots may be misleading and initiate an unnecessary and traumatic attack on a foreign body that is not present. Uncooperative children may have to be mummied or sometimes put under general anesthesia. Rust rings may be removed with a dental drill and if this is not feasible application of 1% AgNO₃ or 20% trichloroacetic acid may help soften the ring and allow it to be more easily removed in a day or two. Not infrequently a 48 hour delay alone without chemical intervention will allow enough softening for successful removal. Nor is it always necessary to remove the entire rust ring, since these are usually well tolerated as soon as the defect is covered with epithelium.

After blasts or explosions there may be myriads of particles and sometimes complete denudation of the corneal epithelium is necessary.

If chemically irritating foreign bodies lie within the corneal stroma they must be removed even at the expense of stromal injury. If a foreign body protrudes into the anterior chamber a miotic must be used to protect the lens while a corneal knife is used to enter the anterior chamber and push the foreign object anteriorly for removal. Depending on the shape, a large opening may be made and the object removed by pulling posteriorly and removing through the wound.

The aftercare of corneal foreign bodies is important. Sometimes none is needed but if the corneal injury is severe, then a cycloplegic, usually homatropine 2% or 5% is needed to thwart the possible onset of reflex secondary iritis.

The uninitiated should be cognizant of the possibility, slim though it may be, of precipitating an acute glaucoma by the in-

stillation of a cycloplegic. In order to promote comfort and/or sleep, an anesthetic and antibiotic ointment should be instilled in the injured eye and an analgesic (codeine, darvon, etc.) and sedative (nembutal, seconal) are essential. A firm dressing that allows the eye to remain passively closed is tightly taped. Few things are more annoying or contrary to good care than the placement of a loose eye bandage. To be convinced one simply need close one eye actively to determine how short a time one can remain comfortable under these circumstances. The application of a loose bandage is one of the commonest faults of all doctors caring for eye injuries. The patient should be examined the next day to determine the presence of an ulcer or an iritis.

The possibility of an intraocular foreign body must be kept in mind and when in doubt an x-ray must be taken.

Corneal Abrasions

One of the most common injuries is frequently due to babies' fingernails, twigs and paper cuts. An analgesic, antibiotic, sedative and firm bandage are necessary and patients should be admonished to use a lubricant morning and night for several weeks to reduce the possibility of a recurrent erosion of the cornea. The latter is characterized by sharp pain on opening the eye after sleeping and is due to pulling off the corneal epithelium.

Contusions are crushing injuries of the globe without perforation. They may occur from large solid objects traveling at high speed, or may be due to blast (air or water) directly to the globe or indirectly from the orbit. The complications include:

- 1) Subconjunctival hemorrhages; unim-



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residency training at the University of Illinois Eye and Ear Infirmary.

portant and clear up spontaneously in 7-10 days.

2) Mydriasis; may result from paralyses of the iris sphincter.

3) An anterior chamber hemorrhage with iridodialysis; usually absorbs without complications. However sometimes a heavy fibrinous clot may persist and produce an occlusion of the pupil border or blood staining of the cornea. This latter occurs concomitant with a rise in intraocular pressure. Bed rest and binocular patching with elevated head is recommended. Most agree on dilating the pupil with homatropine, but there is room for argument on this. Fibrinolysin should be considered to avoid blood staining.

4) Iridocyclitis due to trauma; always a threat and for this reason cycloplegics and steroids are used.

5) Cataracts, rosette in type; due to pulling of lens fibers from the suture lines. Rarely does the lens capsule break, but if so the lens must be removed surgically.

6) Dislocated lenses; with accompanying telltale "dancing iris" or iridodonesis.

7) Vitreous hemorrhage; noted by the partial or total absence of the red reflex. It usually absorbs nicely, especially when treated with atropine and bed rest with elevated head. However, sometimes the blood may become organized and result in retinitis proliferans with or without a cyclitic membrane. This complication inevitably causes an irreparable retinal detachment. Usually, however the dictum "never despair of vitreous hemorrhage" applies. In this writer's experience some vitreous hemorrhages clear up completely after as long as two years. On the other hand some of these hemorrhages turn milky to light yellow and never clear. In this instance a vitreous transplant may be considered.

8) Scleral ruptures; may occur at the thinnest points of the globe, namely at the limbus or just behind the insertions of the rectus muscles. This can be a difficult diagnosis to make but should be thought of in the presence of a soft, mushy eye wherein there is usually no red reflex and poor light projection and failure of hemorrhage to clear up. Depending on the severity and after a large circumlimbal incision of conjunctiva one might suture the rupture or enucleate.

9) Choroidal ruptures; seen as crescentic

areas in the posterior pole.

10) Commotio retinae or macular edema; usually clears up, but a few days flat in bed is considered essential in the treatment.

11) Retinal detachment; must always be considered and occurs more often in the predisposed, *e.g.*, high myopia, or cystic degeneration of the retinal periphery. The earlier this happens after injury the more amenable to treatment.

12) A macular hole; may occur late depending on the amount of edema, and of course there is no treatment for this unfortunate complication.

13) Avulsion of the optic nerve; a rare and horrendous complication which occurs in massive blunt injuries or gunshot wounds posterior to the globe.

Perforating Injuries

Patients with perforating injuries without retained foreign bodies must be hospitalized, undergo x-ray examination and be sent immediately to the operating room. Both eyes should be patched with a sterile bandage. The patient should be immediately started on systemic antibiotics, *e.g.*, tetracyclines or chloromycetin. Complications of this type of injury include:

1) Prolapsed iris; if seen early may be repositioned and held inside the anterior chamber with acetylcholine (miochol) applied directly on the iris inside the anterior chamber. When seen late or in the face of a dirty injury, the exposed iris must be excised flush with the cornea which should be sutured or covered with a conjunctival flap.

2) Sympathetic ophthalmia; may occur in any perforating injury but most often with ciliary body trauma. This is a band running around the globe, 6-9mm behind the limbus. Unless beyond hope, the wound should be closed and as much ciliary body as possible should be repositioned. It is permissible to wait and watch carefully for a uveitis response. If the eye is obviously ruined, one must enucleate immediately.

3) Any perforation may predispose to an epithelial downgrowth which, of course, causes intractable glaucoma.

4) Cataract due to capsule rupture; almost always must be removed, but it is important to wait as long as possible in order to remove with greater ease. While waiting, the ocular tension must be watched

carefully.

5) Intraocular hemorrhage; may occur in both the vitreous and the anterior chamber.

6) The possibility of infection should always be kept in mind and prophylactic antibiotics should be started.

Foreign Bodies

Intraocular foreign bodies are dread injuries and require the most precise care. The amount of reaction and ultimate treatment is influenced by the following factors: 1) infection that may be carried in with the foreign body; 2) the location of the foreign body in the eye (most things are well tolerated in the sclera or lens); 3) the type of foreign body (glass, gold, plastics and tantalum are well tolerated, aluminum is reasonably well tolerated, alloys with copper are poorly tolerated, pure copper causes a purulent reaction with resultant chalcosis bulbi, copper is more rapidly injurious than iron, iron is very degenerative and affects every ocular structure leading to siderosis bulbi and blindness, eyelashes and wood become walled off and are fairly well tolerated). Only iron and nickel may be removed with a magnet so it is imperative to find the tool or object that caused the injury.

Enucleation

Enucleation most certainly should never be done when the injury is bilateral and severe, but it must be considered in several instances:

1) Extensive laceration through the center of the cornea, especially if the ciliary body is involved and associated with damage to the lens or loss of vitreous or when vision is reduced to poor light projection.

2) Subconjunctival-scleral rupture with poor light projection, soft tension and no red reflex.

3) Intraocular foreign body with persistent inflammation and poor light projection.

4) Granulomatous type of uveitis following injury to the iris or ciliary body without signs of improvement 10 to 14 days after the injury.

5) Cases where early signs of sympathetic ophthalmia occur in the uninjured eye within the first day or two after the onset of sympathetic ophthalmia in the injured eye. If, however, sympathetic ophthalmia

is well established in each eye avoid enucleation, because sometimes the injured eye may end up with best vision. The use of steroids in cases of sympathetic ophthalmia is imperative.

6) Blind, painful and unsightly eyes are best removed because of the ever present threat of sympathetic ophthalmia and the possibility of neoplasm.

Burns

Chemical burns may be 1) non-progressive, which are usually due to acids since the tissue buffers the reaction. The original injury may be very destructive but the ultimate prognosis can be estimated with some accuracy at the time of injury. 2) Alkalis and vesicant gasses produce progressive injury which may cause little initial damage, but severe and serious late complications may occur. 3) Irritant burns are due to lacrimators (tear-gas).

Ammonia 10% enters the anterior chamber within 15-30 seconds; lewisite in 1½ minutes; NaOH or KOH (lye) in 5 minutes; CaOH (lime) in 5-10 minutes. Products which cause an early slough of the epithelium remove an important barrier to penetration.

Treatment of chemical burns must be instantaneous with an avoidance of specific neutralizers. Water, milk or saline irrigations by the best means at hand, even to plunging the head in water and opening the eyes are the fastest. The pupil must be dilated by means of a cycloplegic. The anterior chamber may have to be opened to release irritating substances or to search for foreign particles. Observation over an extended period is indicated in these cases since the complications of iritis, symblepharon, ankyloblepharon, ectropion, entropion, glaucoma and cataract are quite possible.

Thermal burns due to heat are normally not as severe, due to the blink reflex. Hot grease, boiling water, and flames are the common offenders. Hot grease, for instance, can literally fry the cornea and appear devastating, but may be almost clear after patching for a day or two.

Radiational burns result from

1) Ultraviolet rays from a sun-lamp, an arc welder and the offending agent in snowblindness. These cause only superficial injury and while very painful, the prognosis is uniformly good.

2) Infrared rays may cause retinal damage and cataract if enough exposure is permitted. The cataracts of glass makers (especially in the production of beer bottles and plate glass) and iron workers are due to infrared radiation.

3) X-rays or gamma rays must be prevented from entering the eye.

Electric burns produced by lightning or short circuiting through the body of high voltage current, if not fatal, can produce cataracts. This change is due partly to heat, partly to concussion and partly to chemical changes following electrolytic dissociation.

Ultrasound radiation also may induce cataract formation.

Lid injuries and lacerations form a large portion of ocular injuries and the techniques used in repairing these wounds are a surgical specialty unto themselves and will not be discussed here. Ecchymosis is the simplest example and, of course, is self-resolving.

Orbital Injuries

The orbit is designed to protect the eye-

ball and consequently may take quite a blow without injury. The ultimate effect of such injury may well depend on the configuration of the orbital rim and the depth to which the eyeball fits into it. The "Herb Score" type of injury is only too well known. Emphysema and crepitation on palpation indicate fracture of the orbit and demand x-ray examination. Blowout fractures of the orbital floor may produce all kinds of injuries, e.g., sinking of eyeball into maxillary sinus with consequent diplopia. Fractures of the optic foramina may cause cutting of the optic nerve or pressure thereon with consequent loss of vision and field defect.

Endogenous Poisons

Great ocular damage may be caused by endogenous poisons. Diphtheria and botulism may cause paralyzes of the extraocular muscles. Atabrine produces transitory edema of the corneal epithelium and hepatitis. Tobacco and alcohol cause amblyopia and wood alcohol produces optic atrophy. Merck 2q causes cataracts.

Early Mastectomy Increases Cure Rate

"It appears that a significant decrease in the death rate from this disease (carcinoma of the breast) would result from improved methods of case findings so as to bring more patients to the surgeon at a time when the high five-year cure rate of 75 to 85 percent can be realized by operation.

In this favorable setting of localized disease it is extremely unlikely that minor alterations in the surgical protocol will effect any great improvement. Mastectomy combined with dissection of axillary lymph nodes, generally referred to as "standard" or "classic" radical mastectomy, has a record not improved upon by other methods thus far; it possesses, in addition, the unique advantage of providing the pathologist with a large group of axillary lymph nodes for examination. The extent of involvement of these nodes is the single most important factor in prognosis and in the planning of further management. In our opinion the emotional and cosmetic hazards of radical mastectomy have been overemphasized in the literature.

The likelihood of further axillary or internal-mammary-lymph-node involvement can be gauged from the anatomy of the tumor and its lymph-node metastases; if this involvement shows more than a 20 per cent likelihood, postoperative supervoltage radiotherapy should be given, but, like radiotherapy, it is contraindicated in patients with small outer-quadrant lesions in cases in which the axillary lymph nodes are not involved.

For recurrent or metastatic disease, and for patients seen for the first time with advanced local and inoperable tumors, adrenalectomy, in our hands, has won out over other forms of endocrine manipulation as a means of modifying the biologic activity of the tumor. . . ." (*New England Jl. of Medicine* (Aug. 31) 1967, pp. 460-468.

OBITUARIES

***Dr. Edward C. Albers**, Rochester, Minn., died at the age of 64.

***Dr. James M. Allison**, Chicago, died Sept. 10 at the age of 79. He was a member of ISMS Fifty-Year Club.

***Dr. Naji H. Battat**, Chicago, died Dec. 29 at the age of 45. He served on the staffs of Mount Sinai and Bethany Methodist Hospitals.

***Dr. Joseph S. Bell**, Hoopeston, died Aug. 23 at the age of 69. He served on the staff of the Hoopeston Community Memorial Hospital.

***Dr. Edgar T. Blair**, Springfield, died Dec. 17 at the age of 76.

Dr. Merle I. Corey, Chicago, died Aug. 30 at the age of 62.

***Dr. John W. Dreyer**, the oldest practicing physician and surgeon in Aurora, died at the age of 91. He was president and program chairman of the American Fracture Association, founder of the Aurora Area Blood Bank and a member of ISMS Fifty-Year Club.

***Dr. Bertha G. Fisher**, Forest Park, a practicing physician for more than fifty years, died Dec. 20 at the age of 83. She was a member of ISMS Fifty-Year Club.

Dr. William G. Frank, Chicago, died Aug. 22 at the age of 83.

Dr. Erwin Frankle, Toulon, died Aug. 9 at the age of 74.

***Dr. A. D. Furry**, Monticello, died Dec. 14 at the age of 75. He was past president of the Piatt County Medical Society and a member of ISMS Fifty-Year Club.

***Dr. Timothy R. Hinchion**, Chicago, died Sept. 11 at the age of 85. He served on the staff of the Chicago Wesley Memorial Hospital and was a member of ISMS Fifty-Year Club.

***Dr. John J. Hopkins**, Decatur, died Dec. 4 at the age of 80. He was a member of ISMS Fifty-Year Club.

***Dr. F. E. Inks**, Princeton, died Dec. 6 at the age of 86. He was a member of the College of Anesthetists and a member of ISMS Fifty-Year Club.

Dr. John Lakes, Collinsville, died Dec. 22 at the age of 45.

***Dr. Paul B. Magnuson**, Chicago, died Nov. 4 at the age of 84. He was professor emeritus of surgery and chairman of the Department of Bone and Joint Surgery at Northwestern University Medical School and a member of ISMS Fifty-Year Club.

***Dr. Paul F. Martin**, Belleville, died July 2 at the age of 89.

Dr. Earl S. McRoberts, Miami Shores, Fla., died Nov. 28 at the age of 73. He was chief of staff at the Lutheran Deaconess Hospital, Medinah medical staff and chairman of the travelog committee of the Illinois Athletic Club and was the first medical examiner for the F.B.I.

Dr. Edward J. Miller, Chicago, died Sept. 13 at the age of 53.

***Dr. Charles D. Nobles**, Anna, former director of Anna State Hospital, died at the age of 87. He was past president and secretary of Union County Medical Society and a member of ISMS Fifty-Year Club.

***Dr. Abraham Nygood**, Chicago, died Sept. 22 at the age of 71.

***Dr. Hiram E. Ogle**, Lake Worth, Fla., died Aug. 12 at the age of 86. He practiced in Potomac and was a member of ISMS Fifty-Year Club.

***Dr. George Parker**, who practiced medicine in Peoria for 59 years, died Nov. 27 at the age of 91. He was past president of the St. Francis Hospital staff, Peoria Medical Society; past president and medical director of the Peoria Life Insurance Company, past president and chairman of the medical section of the Illinois State Medical Society and a member of ISMS Fifty-Year Club.

***Dr. William W. Patrick**, Evanston, died Dec. 11 at the age of 61. He was on the staff of Alexian Brothers Hospital and a member of the Chicago Society of Industrial Medicine and Surgery.

***Dr. Alan C. Siegel**, Winnetka, died Dec. 9 at the age of 44. He was associate medical director and head of the kidney transplant unit at Children's Memorial Hospital and associate professor of pediatrics at Northwestern University Medical School.

Dr. Vlado J. Tomich, Chicago, died Dec. 5 at the age of 55.

***Dr. Peter Vanikiotis**, Oak Park, a staff physician at Garfield Park Community Hospital for 25 years, died Dec. 28 at the age of 50.

Dr. John Paul Walker, Lincoln, died Sept. 28 at the age of 51.

Dr. William L. Winters, Easton, died Aug. 12 at the age of 72. He served on the staffs of the Cook County Hospital, Lake Forest Hospital and the Highland Park Hospital.

***Dr. Raymond Zbick**, Chicago, died Dec. 10 in Lutheran General Hospital, where he was an anesthesiologist, at the age of 40.

*Indicates member of Illinois State Medical Society.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

ISMS Keogh Plan Enrollment More Than Doubles in 1968

Thanks to the recent tax break incentive, enrollment in the ISMS Keogh tax-qualified retirement program more than doubled in 1968. Over the past year the program grew from 68 plans with 156 participants to 183 plans with 370 participants, Paul H. Robinson, Jr., administrator, reports. About half the participants are physicians in clinics and private practice; the rest are eligible employees, as required by the Keogh Act. Total enrollment in tax-qualified programs would have been even greater if medical corporations were clearly eligible, Robinson noted. That question is moot because of different rulings by the Internal Revenue Service and the courts.

State RMP Director Urges County Society Endeavor

County medical societies should play a vigorous role in the development of subregions under the Illinois Regional Medical Program, says Dr. Wright Adams, the program's executive director. "Medical leadership is needed badly," he told the ISMS Board of Trustees last month. Physicians who do participate, he added, tend to wear "their hospital-staff hat but not their medical society hat." Asked to mention some RMP subregions which are making progress, he cited the Evanston/Skokie and Peoria areas.

Consolidate Welfare Programs, ISMS Tells Medicaid Hearing

Dr. Philip G. Thomsen, ISMS president, called for consolidation of Medicaid and other tax supported welfare programs at a federal hearing in Chicago, December 30. Consolidation, he said, would put existing services and facilities to better use, channel patients more effectively, and reduce operating costs. Dr. Thomsen praised Medicaid for "putting its patients into the mainstream of medicine" and letting them choose their own doctor, instead of entrusting them to "a closed panel of welfare-case specialists." This "open atmosphere," plus the usual-and-customary fee program adopted in January, 1967, have encouraged some 6,000 Illinois physicians to participate—almost double the figure of June, 1967, he said. The Department of Health, Education and Welfare sponsored Medicaid hearings in nine cities as guidance for recommendations to Congressional committees.

(Continued on page 190)

practice management **NEWS**

A Service of the Public Relations and Economics Division

Health Insurance Claim Form Revised

Standardized forms for Health Insurance claim statements have become "the way of doing it" for thousands of Illinois physicians and medical assistants. (A sample form is shown on the following page.)

These forms have reduced confusion, time and costs in the paperwork on group and individual claims.

They were developed by your ISMS and AMA in cooperation with the Health Insurance Council, which represents a majority of the U.S. insurance companies offering protection against health-care costs. The HIC emblem appears in the form's left center.

These "Comb-1" forms were revised in October, 1967, and that date appears in the the bottom right corner of the current version. The revision was designed for greater simplification and clarity, and for easy adaptability to electronic-data processing. Also, it draws a division between questions to be answered by the patient, and those to be answered by the physician.

Doctors' offices may obtain the new forms by writing the Division of Public Relations & Economics, Illinois State Medical Society, 360 N. Michigan Avenue, Chicago, 60601. Meanwhile they may use the 1964-dated forms.

Completed forms, of course, should be sent to the insurance company involved.

Some major industrial corporations have their own group-policy forms. The doctor's office may fill out and submit his HIC form—attaching the other but leaving it blank except for pertinent information not covered in HIC's.

If an insurance company or group policy-holder insists on completion of its own form—and this requires "lengthy, detailed information beyond the customary data"—the physician may request a nominal fee, said HIC officials. He also may do so on follow-up data requests.

(Do you have any questions or suggestions on office procedure that would interest your fellow physicians? If so, send them to "Practice Management News," Illinois State Medical Society, 360 N. Michigan Avenue, Chicago, 60601.)

HEALTH INSURANCE CLAIM - GROUP OR INDIVIDUAL

CODE 1 (10-67)

PART A

TO BE COMPLETED BY PATIENT (INSURED)

Spaced for Typewriter - Marks for Tabulator Appear on this Line

PATIENT'S NAME AND ADDRESS		DATE OF BIRTH
INSURED'S NAME IF PATIENT IS A DEPENDENT		
NAME OF INSURANCE COMPANY	POLICY NUMBER	INSURED'S SOCIAL SECURITY NUMBER
IF GROUP INSURANCE, NAME OF POLICYHOLDER (i.e. Employer, Union or Association through whom insured)		

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.

SIGNED (INSURED PERSON)

DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

SIGNED (PATIENT, OR PARENT IF MINOR)

DATE

PART B

ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS

(IF DIAGNOSIS CODE OTHER THAN ICDA* USED, GIVE NAME):

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☐

PREGNANCY?

YES ☐ NO ☐

IF YES, APPROXIMATE DATE PREGNANCY COMMENCED. DATE

3. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES†	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE - IF USED (IF CODE OTHER THAN CPT** USED, GIVE NAME)	CHARGES

TOTAL CHARGES ▶ \$

AMOUNT PAID ▶ \$

BALANCE DUE ▶ \$



†O—Doctor's Office
H—Patient's Home

IH—Inpatient Hospital
OH—Outpatient Hospital

NH—Nursing Home
OL—Other Locations

*ICDA—International Classification of Diseases

**CPT—Current Procedural Terminology (current edition)

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☐ IF "YES" WHEN AND DESCRIBE:

7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?

YES ☐ NO ☐

8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK).

FROM THRU

9. PATIENT WAS PARTIALLY DISABLED.

FROM THRU

10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

11. PATIENT WAS HOUSE CONFINED.

FROM THRU

12. DOES PATIENT HAVE OTHER HEALTH COVERAGE?

YES ☐ NO ☐ IF "YES" PLEASE IDENTIFY13. I DO NOT ACCEPT ASSIGNMENT. ☐

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE
STREET ADDRESS		CITY OR TOWN	STATE OR PROVINCE	ZIP CODE

MEMORANDUM REGARDING DISPOSITION OF THIS FORM ON REVERSE SIDE

Approved by Council on Medical Service, AMA 10-67

AMA Urges Tax-Credit Insurance as Future Medicaid Alternative

The AMA, in a statement to the HEW hearing, also called for consolidation, declaring that Title XIX (Medicaid) should be made "the focal point for federal involvement in health care." As a long-range alternative to growing Medicaid, the AMA (and Dr. Thomsen) suggested federal income-tax credits and vouchers to help lower-income families obtain full health-insurance coverage from private sources.

Cook County Aid Official Asks Hospital Cooperation

David L. Daniel, deputy director of Cook County public aid, called for administrative cooperation in resolving Medicaid problems. "Few hospitals seem to have administrative units geared to handle adequately the referral details of a program of this size and complexity," Daniel told the HEW hearing. "Yet we in welfare are dependent upon the hospital as a referral source."

Hospital Association Seeks Revisions in Medicaid Setup

The Illinois Hospital Association recommended—at the HEW hearing—these changes in the Medicaid program:

1. Clearer determination of eligibility in MA-NG (Medical Assistance—No Grant) cases. "Certification (or denial) for a very high proportion of patients is not received until after they are discharged from the hospital."
2. Designation of Blue Cross as intermediary to process claims and payments in Illinois. This has been done in several other states, said David M. Kinzer, IHA executive director.
3. Interim financing devices to help hospitals bearing a heavy public-aid caseload. Such methods already are used under Medicare, Kinzer noted.

M.D.s Get Reminder on IDPA Prescription Forms

Standard forms from the Illinois Department of Public Aid must be used for drug prescriptions in IDPA cases. The form must include the physician's own or authorized signature, along with his medical-education number and the pharmacist's signature. An ordinary prescription form is insufficient even if the patient shows his IDPA identification card. Authorized refills, however, can be handled strictly through the pharmacy. Dr. Robert C. Muehrcke, chairman of the ISMS Subcommittee on Drugs and Therapeutics, issued this reminder to clear up any confusion.

Patient/Doctor Contacts in U.S. Approaching One Billion Mark

Americans saw or telephoned their physicians 831,000,000 times from July, 1966, to June, 1967, says a Government report. House calls accounted for 3.3% of the total—as against 10.2% a decade earlier. Average costs were \$7.80 for office visits, \$7.90 for house calls.

(Continued on page 211)

Meeting Memos

Feb. 20—Cook County Hospital

Lectures in Anesthesiology
Karl Meyer Hall, 720 S. Wolcott Ave., Chicago
"Therapy of Muscular Skeletal Pain"

Feb. 21—American Society of Anesthesiologists

Houston, Texas
Symposium on Anesthesia for the Cancer Patient

Feb. 21-22—Good Samaritan Hospital

Phoenix, Arizona
Postgraduate Continuation Course in Gastroenterology

Feb. 22-25—American Society of Anesthesiologists

University of Utah College of Medicine
Salt Lake City, Utah
14th Annual Postgraduate Anesthesiology Course

Feb. 24—The Chicago Society of Internal Medicine

Drake Hotel, Chicago

Feb. 24—College of American Pathologists

Ambassador Hotel, Los Angeles, Calif.
Interim Meeting—Market Research Seminar In Steroid Hormones

Feb. 27—Cook County Hospital

Lectures In Anesthesiology
Karl Meyer Hall, 720 S. Wolcott Ave., Chicago
Local Anesthesia Symposium
"Pharmacology & Toxicology: Mechanism of Action, Reactions & Treatment"

March 2-6—American Society of Anesthesiologists

Americana Hotel, Bal Harbor, Fla.
43rd Congress-International Anesthesia Research Society

March 3-7—New York University Medical Center

550 First Avenue, New York City, New York
Symposium on Arthritis and Related Disorders

March 6—Cook County Hospital

Lectures in Anesthesiology
Karl Meyer Hall, 720 S. Wolcott Ave., Chicago
"Basic Electrocardiography I"
"Basic Electrocardiography II"

March 13-14—University of Wisconsin Medical Center

Madison, Wisconsin
"A Clinical Approach to Coronary Artery Disease"

March 13—Cook County Hospital

Lectures in Anesthesiology
Karl Meyer Hall, 720 S. Wolcott Ave., Chicago
"Motor Points and Peripheral Nerve Blocks in Spasticity"

March 14-16—Chicago Medical School/University Health Sciences

Mount Sinai Hospital Medical Center, Chicago
"Techniques of Brief Psychotherapy"

March 18—International College of Surgeons

1524 Lake Shore Drive, Chicago
13th Series of Lectures
"Stay Alive"

March 21-22—American Medical Association

Philadelphia Marriott Motor Hotel
Philadelphia, Pa.
22nd National Conference on Rural Health

CHICAGO MEDICAL SOCIETY

1969

ANNUAL CLINICAL CONFERENCE

SUNDAY, MARCH 2 - WEDNESDAY, MARCH 5

Palmer House, Chicago

The Clinical Conference of the Chicago Medical Society is one of the most important of the Society's activities, and one of the most important medical conferences conducted in the United States each year.

The 25th Clinical Conference of the Chicago Medical Society will take place at the Palmer House, Chicago, starting Sunday, March 2, and continuing through Wednesday, March 5.

For program or registration information address:

Clinical Conference Committee, Chicago Medical Society
310 South Michigan Avenue, Chicago, Illinois 60604

THE EARLY SYMPTOMS OF OSTEOPOROSIS

low back pain
muscle spasm

OFTEN RESPOND
TO CALCIUM
THERAPY



In postmenopausal and geriatric patients, low back pain of unspecified origin may be symptomatic of the early stages of osteoporosis and calcium depletion. Treatment with Calcium-Forte, a form of calcium readily available for absorption, may help to restore a positive calcium balance. In doing so, often it can alleviate the symptoms and help to arrest the progress of osteoporosis by preventing further skeletal damage.

One packet of Calcium-Forte contains the equivalent of 500 mg. elemental calcium, the same amount found in one-half quart of milk.

- ☐ pleasant tasting ☐ highly concentrated
☐ readily soluble

Indications: As an adjunctive measure for major calcium depletion states, which require elemental intakes higher than normal dietary supplements can provide, such as the initial stages of postmenopausal and senile osteoporosis and advanced osteoporosis; also adjunctively with Vitamin D for the treatment of mild or latent hypocalcemic tetany.

Contraindications: Lithiasis, hypercalcemia, cardiac or renal failure.

Precautions: If the patient has a history of renal disease, administration of Effervescent Calcium Granules should be accompanied by abundant intake of acidulous liquids such as fruit juices to avoid hypercalciuria. Should hypercalciuria occur, dosage should be reduced accordingly. Due consideration should be given to the sodium content of Effervescent Calcium Granules when treating patients requiring low sodium diets.

Side Effects: In high doses may cause indigestion or diarrhea. Constipation may occur occasionally.

Composition: Each packet of orange-flavored Effervescent Calcium Granules contains 2.94 grams of the double salt calcium lactate-gluconate and 0.30 grams of calcium carbonate (also contains 325 milligrams of sodium per packet).

New
CALCIUM-FORTE
(Effervescent Calcium) Granules



SANDOZ PHARMACEUTICALS, HANOVER, N.J.

Northwestern Surveys Student Smokers

Sixty-two percent of Northwestern University students do not smoke, according to a recent American College Health Association report on smoking. Fifty-four percent never smoked or smoked very little, and eight percent gave up smoking. Of the 38 percent who do smoke, nearly half—or 42 percent—started smoking in college.

This contradicts a commonly-held belief that by the time students reach college their smoking habits are fixed, said Leona Yeager, M.D., director of the Northwestern University Health Service. Forty-five percent of smokers at Northwestern started in high school and 13 percent started before high school, said Dr. Yeager.

The Association study reported results of an eight-page questionnaire distributed to 2,000 randomly-selected students at Northwestern in 1967. Of these, 1,500 students responded. The Association distributed the questionnaire to students at 50 U.S. universities and colleges. Northwestern is one of two schools for which the Association has tabulated results.

Other statistics on smoking at Northwestern released by the Association:

48 percent of those belonging to a social fraternity or sorority smoke (49 percent in sororities; 44 percent in fraternities).

41 percent of dormitory residents smoke.

23 percent of those living at home smoke.

Social studies students were the heaviest smokers; students of the physical sciences the lightest:

Social studies, 46 percent.

Fine arts, 45 percent

Education, 38 percent.

Biological sciences, 27 percent.

Engineering, 23 percent

Physical science, 21 percent.

Low-cost medical care is available to the public at the University of Illinois Hospitals, 840 South Wood Street, on the west side Medical Center Campus. Patients are billed according to their ability to pay in clinics covering everything from allergies to tumors. A patient's value as a "teaching case" for faculty and students is one of the many considerations for admission to one of the clinics.



**painful night
leg cramps...**

**respond to specific
therapy with
QUINAMM™**
(Quinine sulfate, 260 mg.,
Aminophylline, 195 mg.)

THE BETTMANN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

no

gag



DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:
Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.

(Warning: May be habit forming)

To reduce hypermotility and frequency.

Homatropine Methylbromide... 0.15 mg.

A safe dose for mild spasmodic to curb cramping and griping.

Pectin... 24. mg.

Demulcent, adsorbent. Helps form stools.

Alcohol 10% by volume.

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's rule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

DIA-QUEL LIQUID



INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976

**ILLINOIS
MEDICAL
ASSISTANTS
ASSOCIATION
REPORT**



Is Her AAMA Showing?

With the increased demands on our doctors today it is almost impossible for the doctor to take the time to train a lay person to be his medical assistant. The American Medical Assistants Association offers the opportunity to increase efficiency by greater knowledge of important skills.

In May, 1955, the organization now known as AAMA was conceived. In October, 1956, 156 women met in Milwaukee and chose Miss Maxine Williams as first president of AAMA. One year later at the House of Delegates of the American Medical Association a resolution was passed commending the objectives of AAMA. Forty-five organized states with approximately 12,500 members now form AAMA.

There are many benefits to national membership: For example, the approval program which will benefit every medical assistant can be carried on only by a national committee. The certification program is an endeavor requiring national leadership and supervision.

A partial list of benefits which AAMA offers to a medical assistant are:

1. Articles of professional value to the person seeking self improvement.
2. Tips on efficient office procedures.
3. Study classes for self-education thru home study or free group study courses.
4. Program suggestions that aid chapters planning stimulating programs.
5. Leadership training provided thru seminars arranged by AAMA with trained leadership counselors in charge.
6. Improved service in answering corres-

pondence for AAMA materials.

7. One of the future plans is to have a national placement service to help doctors find assistants and medical assistants to find new positions.

What is your medical assistant's rating? Does she have the skills to get the job done? The ideal medical secretary is the keeper of medical secrets, and should be able to deal with the unexpected new tasks with versatility. She must be able to follow through on the small things that soon add up to the success of a job. She must be tactful and courteous.

Today members are participants at county, state and national levels. County chapters hold monthly meetings. Programs are planned to include speakers with a wide variety of interesting information, helpful and broadening to a medical assistant. Programs in some counties have included information regarding secretarial skills necessary in a doctor's office, modern obstetrics and a normal delivery, educable brain-damaged children, alcoholism as a community problem, and medical missionaries in Africa.

Once a year each state holds a convention where much can be learned to increase one's knowledge and skills. The programs are presented by doctors and informed para-medical personnel who give generously of their time to present their ideas in medicine, surgery or a special field they represent.

Physicians are asked to encourage their assistants in considering AAMA membership. The benefits will accrue to the physician.



She's on "the pill."

**When she gets a bacterial infection,
think of Tetrex-F.®**

Like the debilitated or diabetic patient, she may be susceptible to monilial overgrowth.

That's why she needs the extra protection of Tetrex-F whenever tetracycline therapy is indicated. Tetrex-F provides well-tolerated tetracycline phosphate complex for the bacterial infection—nystatin to help prevent monilial overgrowth.

Tetrex-F[®]

(tetracycline phosphate complex-nystatin)

**Whenever monilia may threaten
tetracycline therapy**

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A. H. F. S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

NEW

PHARMACEUTICAL

SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

NEW SINGLE CHEMICALS

INFLUENZA VACCINE Biological R

Manufacturer: Merck Sharp & Dohme

Nonproprietary Name: Influenza virus vaccine, monovalent, Hong Kong strain.

Indications: Immunization against the Asian flu.

Contraindications: Hypersensitivity to eggs, chicken, or chicken feathers.

Dosage: Adults and children over 10 years: 1 cc., s.c. Children 6 to 9 years: 0.5 cc., s.c.

Children 3 months to 5 years: 0.1-0.2 cc., s.c., on two occasions, one to two weeks apart.

Supplied: Vials—4,000 CCA/10cc.

DUPLICATE SINGLE PRODUCTS

EQUGEN Hormones—Estrogens R

Manufacturer: Paul B. Elder Co.

Nonproprietary Name: Estrogenic Substances, Conjugated Equine.

Indications: Menopausal syndrome, senile vaginitis, Kraurosis vulvae, pruritis vulvae, amenorrhea, dysfunctional uterine bleeding, palliative in prostatic carcinoma.

Contraindications: Women with genital malignancies, pre-menopausal women with breast carcinoma.

Dosage: 1 tablet daily.

Supplied: Tablets—1.25 mg.; bottles of 20, 100, and 1,000.

INFLUENZA VIRUS VACCINE Biological R

Manufacturer: Eli Lilly & Co.

Nonproprietary Name: Influenza virus vaccine, monovalent, Hong Kong strain.

Indications: Immunization against the Asian flu.

Contraindications: Acute respiratory disease or other active infection, hypersensitivity to eggs.

Dosage: Adults and children over 10 years: 0.5 cc., s.c. Children 6 to 10 years: 0.25 cc., s.c.

Children 3 months to 6 years: 0.05 to 0.1 cc., on two occasions, one to two weeks apart.

Supplied: Vials—2,000 CCA units/2.5 cc.

LEDERCILIN-VK Antibiotic—Penicillin R

Manufacturer: Lederle Laboratories

Nonproprietary Name: Penicillin, Potassium Phenoxymethyl.

Indications: Infections caused by penicillin-susceptible organisms, such as streptococci, pneumococci, gonococci, and some strains of staphylococci.

Contraindications: Hypersensitivity to penicillin.

Dosage: Adults and children over 12 years: from

125 mg. t.i.d. to 500 mg. q.4h.

Children under 12 years: adult dosage adjusted accordingly.

Supplied: Tablets—250 mg.; bottles of 100 and 1,000.

TUBERCULIN P.P.D. R

Solution Diagnostic—Dermal

Manufacturer: Panray Division

Ormont Drug & Chemical Co., Inc.

Nonproprietary Name: Tuberculin Purified Protein Derivative, Dilute.

Indications: Intracutaneous testing for tuberculosis.

Contraindications: None mentioned.

Dosage: 0.1 cc. intracutaneously.

Supplied: Vials—First strength, 1 cc.

Intermediate strength, 1 and 5 cc.

Second strength, 1 cc.

COMBINATION PRODUCTS

ALLYLGESIC R

w.Ergotamine Migraine Therapy

Manufacturer: Paul B. Elder Co.

Composition: Aspirin 150 mg.
Acetaminophen 100 mg.
Aluminum aspirin 100 mg.
Allobarbitol 15 mg.
Ergotamine tartrate 1 mg.

Indications: Recurrent throbbing vascular headache, migraine, migraine variants, histaminic cephalalgia, headache complicated by tension.

Contraindications: Peripheral vascular disease, coronary heart disease, hypertension, impaired renal or hepatic function, sepsis, pregnancy. Hypersensitivity to any of the components.

Dosage: Adults: 2 caps. at onset of attack, then 1 cap. q.½h., maximum 6 caps. per attack or 10 caps. in 7 days.

Supplied: Capsules—bottles of 20, 100, and 500.

DILOR-G Bronchial Dilator R

Manufacturer: Savage Laboratories

Composition: Dyphylline 200 mg.
Glyceryl guaiacolate 200 mg.

Indications: Bronchial asthma, emphysema, bronchitis, pneumonitis, and other related bronchopulmonary insufficiency conditions.

Contraindications: Concomitant administration with ephedrine or other sympathomimetic drugs.

Dosage: Adults: 1 tablet 3-4 times daily.

Children over 6 years: 2-3 mg. dyphylline per lb. body weight, daily, in divided doses.

Children under 6 years: Not recommended.

Supplied: Tablets—bottles of 100 and 1,000.

DILOR-G Liquid Bronchial Dilator R

Manufacturer: Savage Laboratories

Composition: Each 5 cc. contains:
Dyphylline 100 mg.
Glyceryl guaiacolate 100 mg.

Indications: Bronchial asthma, emphysema, bronchitis, pneumonitis, and other related bronchopulmonary insufficiency conditions.

Contraindications: Concomitant administration with ephedrine or other sympathomimetic drugs.

Dosage: Adults: 1 or 2 tsp. 3-4 times daily.

Children over 6 years: 2-3 mg. dyphylline per lb. body weight, daily, in divided doses.

Children under 6 years: Not recommended.

Supplied: Liquid—bottles of 1 pint and 1 gallon.

DIMETHACOL Antispasmodic R

Manufacturer: Strassenburgh Laboratories

Composition: Methscopolamine 5 mg.
Methaqualone 20 mg.

Indications: Peptic ulcer, gastroenteritis, painful

(Continued on page 204)

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

ibadubdub lubadi

Anxiety is expected in the cardiovascular patient. A little may even be desirable.

But when anxiety is exaggerated . . . when it interferes with sleep . . . when it aggravates cardiovascular symptoms, your help may be needed.

Naturally, you'll want to reassure the patient.

And perhaps prescribe Equanil (meprobamate) as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently.

Almost 15 years' use has shown that Equanil is usually well tolerated as well as effective. Side effects are generally limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil[®]
(meprobamate) 

New Pharmaceutical Specialties

(Continued from page 200)

spasm, hyperacidity, dyspepsia.
Contraindications: Glaucoma, urinary bladder neck obstruction, and pyloric obstruction.
Dosage: One capsule q.12h.
Supplied: Capsules—bottles of 100.

MALLAGESIC Analgesic—Non-narcotic R
Manufacturer: Mallinckrodt Pharmaceuticals
Composition: Acetaminophen 500 mg.
 Butabarbital 16 mg.
Indications: Relief of pain associated with nervous tension.
Contraindications: None mentioned.
Dosage: Adults: 1 tablet q.4h., not to exceed 5 tab./24 hours.
 Children 8-12 years: ½ tab. q.4-6h., not to exceed 2 tab./24 hours.
Supplied: Tablets—bottles of 100 and 1,000.

OTOMYXIN Ear Preparation R
Manufacturer: Paul B. Elder Co.
Composition: Polymyxin B sulfate 2,000 U.
 Neomycin sulfate 0.35 %
 Hydrocortisone 0.25 %
 Dipreron HC1 0.50 %
Indications: External otitis.
Contraindications: Tuberculous, fungal or viral conditions of the skin; patients with a history of sensitivity to any of the ingredients.
Dosage: 3-4 drops three times daily in the affected ear.
Supplied: Liquid—dropper bottles of ½ oz.

PRAMILET-FA Vitamin/Mineral Comb.-Pre-natal R
Manufacturer: Ross Laboratories
Composition: Folic acid—0.35 mg.
 Vitamins: A, B₁, B₂, B₅, B₆, B₁₂, C, D, niacinamide.
 Minerals: iron, calcium, magnesium, zinc, iodine, copper.
Indications: Supportive nutritional supplementation during pregnancy.
Contraindications: None mentioned.
Dosage: One tablet daily.
Supplied: Filmtabs—bottles of 100.

SINUBID Cold Prep.-General o-t-c
Manufacturer: Warner-Chilcott Laboratories
Composition: Acetaminophen 300 mg.
 Phenacetin 300 mg.
 Phenylpropanolamine HC1 100 mg.
 Phenyltoloxamine citrate 66 mg.
Indications: Sinus or other frontal headache, sinusitis, allergic rhinitis, vasomotor rhinitis, coryza.
Contraindications: Hypersensitivity to any of the ingredients.
Dosage: Adults: 1 tablet q.12h.
 Children 6-12 years: ½ tablet q.12h.
 Tablets should not be chewed.
Supplied: Tablets—bottles of 100.

TUSSAR-SF Cough Preparation o-t-c
Manufacturer: Armour Pharmaceutical Co.
Composition: Each 5 cc. contains:
 Codeine phosphate 10 mg.
 Carbetapentane citrate 7.5 mg.
 Chlorpheniramine maleate 2.0 mg.
 Glyceryl guaiacolate 50 mg.
 Sodium citrate 130 mg.
 Citric acid 20 mg.
 Chloroform 15 mg.
 Methylparaben 0.1 %
 Alcohol 12 %
Indications: Relief of severe coughs.
Contraindications: None mentioned.

Dosage: Adults: 1 tsp. 3-4 times daily, not to exceed 8 tsp./24 hours.

Supplied: Syrup, sugar-free—1 pint bottles.

VIRIDITE Hypotensive-Alkaloid R

Manufacturer: Paul B. Elder Co.

Composition: Veratrum viride 40 mg.
 Sodium nitrite 65 mg.

Indications: Management of angina pectoris with hypertensive complications.

Contraindications: Known hypersensitivity to veratrum viride and nitrites, hypotension, coarctation of the aorta, pheochromocytoma, digitalis intoxication, increased intracranial pressure, severe anemia, glaucoma, uremia or idiosyncrasy. Not to be given with quinidine.

Dosage: Initial: 6 tablets daily.

Maintenance: 1 tablet t.i.d., p.c.

Supplied: Tablets—bottles of 100 and 1,000.

VIRIDITE-K Hypotensive-Alkaloid R

Manufacturer: Paul B. Elder Co.

Composition: Veratrum viride 40 mg.
 Potassium nitrite 65 mg.

Indications: Management of angina pectoris with hypertensive complications, when sodium restriction is necessary.

Contraindications: Known hypersensitivity to veratrum viride and nitrites, hypotension, coarctation of the aorta, pheochromocytoma, digitalis intoxication, increased intracranial pressure, severe anemia, glaucoma, uremia or idiosyncrasy.

Not to be given with quinidine.

Dosage: Initial: 6 tablets daily.

Maintenance: 1 tablet t.i.d., p.c.

Supplied: Tablets—bottles of 100 and 1,000.

NEW DOSAGE FORMS

EXTENDRYL CHEWABLES R

Cold Prep.-General

Manufacturer: Fleming & Co.

Composition: Phenylephrine HC1 10 mg.
 Chlorpheniramine maleate 2 mg.
 Methscopolamine nitrate 1.25 mg.

Indications: Respiratory congestion and discharge accompanying the common cold, allergic rhinitis or sinusitis.

Contraindications: Glaucoma, hypersensitivity to any of the components.

Dosage: Adults: 1 or 2 tablets q.3-4h.

Children 6-12 years: 1 tablet q.4-6h.

Children under 6 years: ½ tablet q.4h.

Supplied: Tablets—chewable.

HEPICEBRIN Vitamin Combination o-t-c

Manufacturer: Eli Lilly & Co.

Composition: Vitamins A, B₁, B₂, B₃, C, and D.

Indications: Prevention and treatment of multiple vitamin deficiencies.

Contraindications: None mentioned.

Dosage: 1-3 tablets daily.

Supplied: Tablets—bottles of 100 and 1,000.

LEDERCILLIN-VK R

for Oral Sol. Antibiotic-Penicillin

Manufacturer: Lederle Laboratories

Nonproprietary Name: Penicillin, Potassium Phenoxymethyl

Indications: Infections caused by penicillin-susceptible organisms, such as streptococci, pneumococci, gonococci, and some strains of staphylococci.

Contraindications: Hypersensitivity to penicillin.

Dosage: Adults and children over 12 years: from 125 mg. t.i.d. to 500 mg. q.4h.

Children under 12 years: adult dosage adjusted accordingly.

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MEDICINE IN THE SEVENTIES

ISMS Annual Convention

May 19-21, 1969

Sherman House, Chicago

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Donnagel117	SenokotThird Cover
A. H. Robins & Company	Purdue Frederick Company
Empirin Compound with Codeine127	Soyalac122
Burroughs Wellcome & Co.	Loma Linda Foods
Equanil202-203	Tepanil Ten-Tab112, 186
Wyeth Laboratories	National Drug Co.
Gelusil-M191-192	Tetrex-F199
Warner-Chilcott Laboratories	Bristol Laboratories
Histoplasmin220	Tuberculin, Tine Test219
Lederle Laboratories	Lederle Laboratories
Librium124-125	Trocinate218
Roche Laboratories	Wm. P. Poythress
LomotilSecond Cover	V-Cillin K, Pediatric132
G. D. Searle & Company	Eli Lilly & Company
Mediatric114-115	
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You see many depressed patients who hide their real anxieties behind a smoke screen of pretense. The more they try to conceal reality, the more entrenched the disturbances become. The role they assume is not adequate to suppress their inner turmoil. Unchecked, the turmoil finds expression in other symptoms.

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lift the depression,
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AMA Socio-Economic Congress Booked for Chicago in March

Physicians from all over the country will gather in Chicago for the AMA's Third National Congress on Socio-Economics of Health Care. It will be held Friday and Saturday, March 28 and 29, at the Palmer House. Experts will discuss medical-quality evaluation, health-manpower shortages and health-service financing.

ISMS President's Tour Bound for Champaign, Springfield

The ISMS President's Tour will start its 1969 itinerary with districtwide programs Thursday, March 13, at the Champaign Country Club, 1211 S. Prospect, Champaign, and Thursday, March 27, at the St. Nicholas Hotel, Springfield. Each visit will feature: (1) a free Workshop on Government Health Programs from 1 to 5 p.m. for MD's and medical assistants. Experts will outline claim-filing and other procedures—and answer questions—involving Medicare, Medicaid, general assistance, vocational rehabilitation, children & family services and CHAMPUS. (2) A President's Dinner for physicians and their wives at 7 p.m., preceded by a 1-hour reception. Dr. Philip G. Thomsen, ISMS president, will share the rostrum with a prominent public official to be named later.

—By DON B. FREEMAN

Population Statistics and Characteristics

The population of the United States at ages 18-24 increased from 16.1 million in July, 1960, to almost 22.3 million in mid-1967, according to statisticians of Metropolitan Life Insurance Company.

This gain of 38% was three and three-fourths the growth rate for the population at all ages combined. Moreover, the number of young people is expected to continue increasing rapidly, and may reach 29.6 million by 1980. Persons at ages 18-19 are expected to increase by 22%, and those aged 20-21 by 29%. There will be approximately 8.5 million men and women in each of these age groups by 1980.

Even more marked growth is expected of the 22-24 age group, some 45%, to over 12.5 million in 1980.

Statisticians point out that these growth trends will have an important impact on our social and economic life.

Also evident is change in living arrangements between ages 18-19 and 22-24, indicating that early family formation is characteristic of American life. Among men 18-19 years of age, for example, 81% live with their parents or in another relative's

household. But in the 22-24 age group, only 36% do. Over this same age span, men who are the head of a household increase from 5% to 46½%. This shift reflects the increasing numbers marrying at this period of life. Thus, the proportion of married men rises from 61½% at ages 18-19 to about 54½% for the 22-24 year olds.

Since females usually marry at younger ages than males, a much larger proportion of the women are married at ages 18 through 24. The proportions are 23% for women aged 18-19 and 74% for those 22-24 years. In consequence, women tend to change their living arrangements at an earlier age than men. At ages 18-19, over 17% are wives of household heads, and at ages 22-24, the proportion is as high as 64%. Relatively few women head their own households at these ages; the proportion is less than 7% even for those aged 22-24 years.

Our population at ages 18-24 has attained relatively high educational levels. Almost two-thirds of the men and three-fourths of the women have at least finished high school; 1.1 million have graduated from college.

New Pharmaceutical Specialties

(Continued from page 204)

Infants: 25-50 mg./kg./day, in 3-6 divided doses.

Supplied: Powder for Oral Solution—125 and 250 mg./5cc.; bottles of 80 and 150 cc.

MULTICEBRIN Vitamin Combination o-t-c
Manufacturer: Eli Lilly & Co.

Composition: Vitamins A, B₁, B₂, B₃, B₆, B₁₂, C, D, E, and pantothenic acid.

Indications: Prophylaxis or treatment of vitamin deficiencies, as general daily dietary supplement.

Contraindications: None mentioned.

Dosage: One or more tablets daily, as directed by physician.

Supplied: Tablets—bottles of 100 and 1,000.

OPITHEL Ointment Eye preparation R

Manufacturer: Paul B. Elder Co.

Composition: Each gram contains:
Zinc bacitracin 400 U.
Polymyxin B sulfate 5,000 U.
Neomycin sulfate 5 mg.

Indications: Prophylaxis and treatment of superficial ocular infections caused by bacitracin-sensitive organisms.

Contraindications: Hypersensitivity to any of the ingredients.

Dosage: Apply locally 1-3 times daily.

Supplied: Ointment—tubes of 1/8 oz.

Psychosomatic Aspects of Headache

(Continued from page 156)

Lastly, it is a constant source of amazement to me why patients who do not have their headaches relieved keep coming back to the same doctor. They will come back eight, ten, fifteen, twenty or even forty times. Why do they keep coming back? Because the doctor helps them handle the symptom and not because they cure them. These people might be worse off if you did cure them.

In headache patients where I feel there is strong hostility, I have them read this little poem by William Blake:

"I was angry with my friend, I told my wrath, my wrath did end; I was angry with my foe, I told him not, my wrath did grow." ◀

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ACHROMYCIN® V TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



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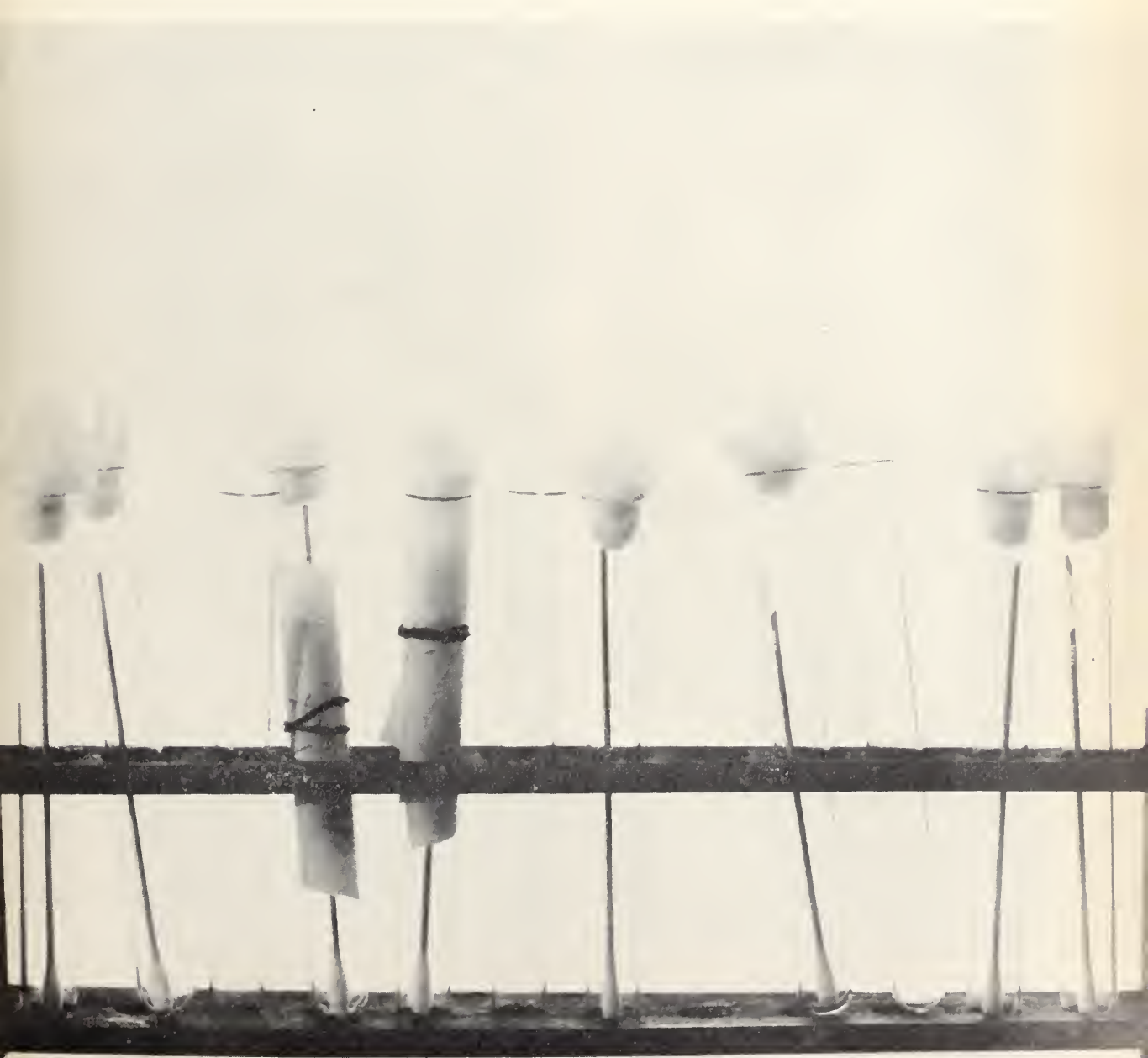
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is inconsequential.*

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"Liberalized" Abortion—A Precedent-Shattering Precedent

BY THE REVEREND CHARLES CARROLL/SAN FRANCISCO, CALIF.

"This is the second of a three-part series of articles based on presentations made at the ISMS Symposium on Abortion during the 1968 Convention. The Symposium was presented by the ISMS Committee on Medicine and Religion. The first article presented the Jewish viewpoint, while that of the Roman Catholic will be the basis for the next article."

We are to discuss therapeutic abortion. Imagine my surprise then in learning that at this time, in this hotel, doctors whom I assumed would meet with us, are gathered together in another room to draft a proposal for acceptance of the model code of the American Law Institute by this convention of the Illinois Medical Society.

The issue, of course, goes far deeper than abortion. It could, if it is not confronted and resolved, lead to an experience for the life scientists akin to that of the physical scientists in New Mexico in the Spring of 1945. Power is never neutral. Atomic energy can be used to build or destroy. The power to define life and death, and to act upon these definitions is still more awesome and its exercise fraught with greater possibilities of good or evil.

When I first participated in the great debate a year and a half ago, there were five reasons which prompted me to oppose the present proposals for "liberalized" abortion.

First, I believe with Dr. George Corner¹ and Dr. Nicholson Eastman², two of the most respected men in obstetrics and gynecology in our country in this century, that life exists in utero.

Second, I believe that individual human life begins with conception; as with Prof. Helmut Thiellcke of the University of Hamburg, that once impregnation has taken place "it is no longer a question of whether the persons concerned have responsibility for a *possible* parenthood; they have *become* parents"³, with Prof. Otto

Piper of Princeton Seminary, that "we have no right to destroy new life"⁴; with Prof. Karl Barth of the University of Basel, that "he who destroys germinating life kills a man"⁵; and with Dietrich Bonhoeffer, the German Protestant martyr, that "abortion is nothing but murder."⁶

Third, I believe that the ultimate purpose of the state is to protect those who cannot protect themselves and to care for those who cannot care for themselves. With the authors of "The Declaration of Independence," I believe that first among man's "inalienable rights" is the right to life. As I oppose capital punishment, so I oppose therapeutic abortion. As the Supreme Court in the case of *Trop vs. Dulles* (1958) spoke of "evolving standards of decency" in raising questions about the morality of the death penalty for the already born, so I would speak of "evolving standards of decency" in raising questions about the morality of the death sentence imposed upon so many of the unborn.

Fourth, I believe with the spokesman for the American medical community at the Nazi doctors' trial at Nuremburg that "the moral imperative of the Oath of Hippocrates is necessary for the survival of the scientific and technical philosophy of medicine"⁷; and of those who claim that this Oath in our land is more "honored in the breach than the observance"⁸, I would ask, "What is the ethic of American medicine? If there is one, is it universally accepted? If there is none, why? Will state discipline not follow the failure of self-

discipline? Has American medicine been granted an immunity against judgment that German medicine was denied?"

Finally, I believe with Teilhard de Chardin that man is something more than a conglomerate of physical and chemical substances; that "he is nothing else than evolution become conscious of itself"⁹; that "from the depths of Matter to the highest peak of the Spirit, there is only *one evolution*"¹⁰; and that is characterized by a "process of the emergence of Spirit out of materiality, of freedom out of necessity, of personality in the human individual out of materiality"¹¹.

In short, I oppose abortion except in those cases where the mother's very life is endangered (a tragic choice of life for life that is becoming increasingly unnecessary thanks to scientific advance), and I oppose its extension for the same reason that I oppose compulsory sterilization; the *de facto* denial of equal rights and equal opportunity to all men, regardless of race, creed, color or national origin; scientific experimentation upon human beings without their "informed consent;" treatment of the severely-injured, brain-damaged patient more as a potential organ donor than a person to be healed; "updating death" if that implies abandonment of the traditional indices and reliance upon the flat reading of an electroencephalogram alone; capital punishment; euthanasia; and armed force as the principal means used in the settlement of domestic or international disputes—the reasons: the sanctity and dignity of individual human life.

Surely, John Donne spoke for me 344 years ago in saying: "no man is an island, entirely of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less. . .; any man's death diminishes me because I am involved in mankind."¹² I am sure he spoke for many others.

The real question the proponents of this legislation have failed to answer in a definitive way is "When does individual human life begin?"

If, as the majority of scientists, they say "with conception," the proponents can then justify abortion before the third trimester of pregnancy only by drawing a distinction between biological and human life. Given this definition, they justify

abortion before the 180th day of pregnancy and the prohibition of abortion with the beginning of the 181st day in claiming that the fetus at this time has become "capable of life independent of the mother." This thesis is as superficial as its implications are frightening. Surely, when individual human life is defined by its capacity for independent existence, we must deny the newly-born, the disabled accident victim and war veteran, the retarded, the mentally ill, and the senile, the poor and the aged any claim to membership in the human family, for they must be cared for and helped by others. But in a deeper sense, such a definition robs us of all acclaim to membership in the human family for no man is truly independent. Beyond our dependence on food and drink, there is our dependence upon the most powerful nutrient of all—human love and affection.

Definitions may appear unimportant, but definitions as ideas can be used as weapons. Hermann Goering, long-time deputy Führer of Nazi Germany, once said, "Who is a Jew, is for me to decide." Six million human beings were incinerated in the gas ovens of the Third Reich because they were labeled "Jew." Some were spared because men in power needed their talents or their bodies. In a world in which we have ample evidence at every hand of man's capacity for enormous good and monstrous evil, we can no longer afford to be careless in formulating definitions of individual human life and individual human death. To paraphrase Edmund Burke, "Evil triumphs when good men become slipshod in their thinking and their phrase-making."

My principal objection to the present proposals for "liberalized" abortion and to the arguments of their proponents rises *not* from their appalling ignorance of the educative role of the law; *not* from their unwillingness to define "mental health" or "physical health"; *not* from their refusal to differentiate between statutory and criminal rape; *not* from their failure to ask for proof of rape or incest; *not* from their indifference in insisting that all possibly deformed may be aborted though their most oft-quoted statistics never claim that "more than half" of these would be deformed; *not* from the disregard of those deformed by accident or war in later life

that this argument demonstrates; *not* from their callousness in granting to the prospective mother the sole right to seek an abortion and their consequent denial to the prospective father of any right to speak in defense of his unborn child (see "*O'Beirne vs. O'Beirne*"—the Superior Court of California in and for the County of Santa Clara and the Supreme Court of California, Oct.-Dec., 1967); *not* from the implicit emotional appeals they make against a celibate, Catholic clergy whom they claim to be their sole opponents; *not* from their claim that legalization of abortion will substantially reduce the great number of illegal abortions, a claim unsubstantiated by the experience of any Western nation; *not* from their argument that suicides because of unwanted pregnancies will decline in face of the statement by two world-renowned experts in suicide prevention (Farberow and Schneidman), that such threats are of "low emergency lethal valence"¹³; *not* from their evident inability to envision or grasp the opportunities for therapy and loving care that the period of pregnancy affords; *not* from their apparent reluctance to mobilize the therapeutic resources of the community in the mother's aid and care, and provide her child, if unwanted by her at delivery, a chance for life and adoption by a childless couple.

No—my principal objection is to the definition of individual human life that inheres in these proposals and the dangerous precedents they establish. Then, any argument designed to escape the charge of "respectable murderer"¹⁴ that begs the question by differentiating between biological life and human life; the point before which and the point after which the life of the fetus becomes independent of its need of the mother: indeed, any argument which equates man with "reason," "reflective thought," "usefulness" could threaten the life of the retarded, the mentally ill, and the disabled.

I do not claim to have achieved a definition acceptable to all men in a pluralistic society. But I insist that we had best be about the task.

If medicine, law, theology and philosophy fail to respond to this challenge to define individual human life, then I fear the

insurance companies, malpractice experts and increasingly greater numbers of concerned citizens will insist upon definitions of life *and* death. Who is to stop the medical instrumentation that alone sustains life? For what purpose? By whose authority? With whose consent? Death cannot be certified where life has not first been recognized. It is just that simple. And when men abandon traditional concepts and values, they had best have some of equal quality and durability at hand. As Jean Jacques Rousseau has said, "The strongest is never strong enough to be always the master, unless he transforms strength into right, and obedience into duty"¹⁵.

Inspired by these concerns, I have addressed a letter to His Holiness, Pope Paul VI. The communication called for an international conference of experts to discuss this concept and for an address to mankind regarding this. Appended to it were the supporting signatures of:

The Chancellor of the University of California, San Francisco Medical Center

The Dean and Associate Dean of the School of Medicine

The Deans of Nursing, Pharmacy and Graduate Study

The Chairman of the Department of Surgery

The Chief of the Transplantation Service

The Professor of Medical Philosophy
The Rector, eleven members of the Faculty, and 46 Scholastics of Alma College, Jesuit Theologate of the Province of California

The Members of the Board of the United Ministeries of Higher Education for Northern California and Nevada (representing eight Protestant denominations)

The Members of the Department of College Work of the Episcopal Diocese of California, and

The Elizabeth Josselyn Boalt Professor of Law at the University of California at Berkeley.

Should this petition fail, then another shall be drafted and forwarded to the World Council of Churches. The hour is already late!

(Continued on page 218)

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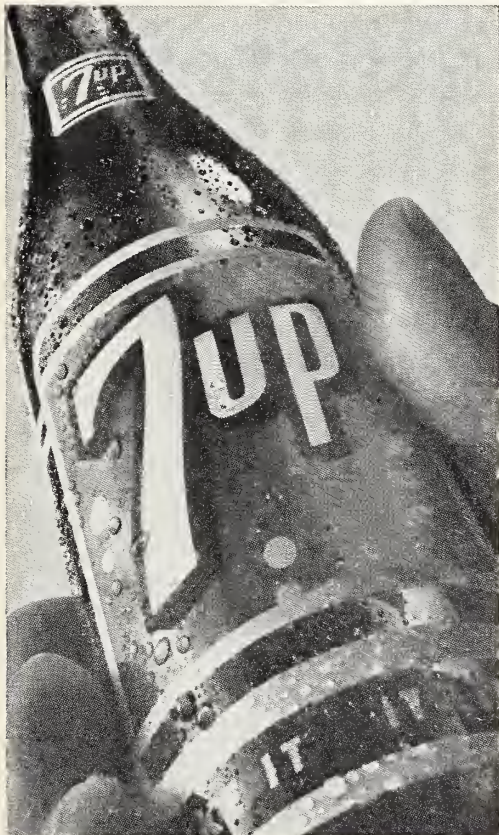
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TROCINATE

BRAND THIPHENAMIL HCl

DIARRHEA

Liberalized Abortion

(Continued from page 216)

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IDPA Payment Procedures

(Continued from page 148)

information. Form 132, returned to the physician for operative report as to size of wound, number of sutures, time and dates involved, was returned with only the notation, "There was no operative room surgery. Suturing of laceration was done in the emergency room."

Question: Does the inclusion of the birth date on the upper portion of Form 132 ever have any influence on the fee paid?

Answer: Yes, because in some cases more is paid for some procedures for adults than for children. Also, a secondary benefit is that the birth date often serves as valuable information when the eligibility of the patient is questionable.

THE VIEW BOX

(Continued from page 145)

Diagnosis: Renal dysgenesis.

The retrograde examination revealed an almost normal length of ureter extending up to the level of the inferior aspect of L3. However the contrast material ran back into the bladder and no evidence of a collecting system is demonstrated. The renal arteriogram reveals a bud like projection slightly above the level of the left renal artery on the right side. There was failure of a nephrogram on the right in the delayed film. At surgery an almost completely normal length of ureter was found and microscopic examination revealed a small island of renal-like tissue at the most proximal portion of the ureter.

Renal agenesis consists of an absolute absence of renal tissue; if the kidney is represented by a nodule of tissue bearing no morphologic or histologic resemblance to normal renal parenchyma it is designated as dysgenesis. In unilateral agenesis the ureter is usually absent and only a small portion of the distal ureter is found. The ureter was never found extending as high as the usual anatomic position of the kidney. In unilateral dysgenesis the ureter was usually seen to be of normal length as in our case. In agenesis and dysgenesis there is no evidence of renal artery on the arteriogram.

Reference:

Leon Love, M.D. and Raymond DesRosier, M.D. "Angiography of Renal Agenesis and Dysgenesis," *Am. J. Roentgen*, 98 (1):137-142, Sept. 1966.

A number of innovations in medical education are being used at the University of Illinois Medical Center Campus on Chicago's near-west side. Among the innovations are a computer that presents a patient's case to a student and allows him to ask questions and make a diagnosis; a telephone system that allows students to dial a number to hear a lecture they missed that same day; lectures presented through a series of slides and tape recordings; and an independent study program where exceptionally-talented students may go through medical school at their own pace.

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SPECIALTY REVIEW COURSE IN MEDICINE, Part II,
March 3
SPECIALTY REVIEW COURSE IN THORACIC SURGERY,
March 10
SPECIALTY REVIEW COURSE IN GENERAL PRACTICE,
March 17
PATHOLOGY REVIEW COURSES FOR SPECIALTIES,
Request Dates
FLUIDS & ELECTROLYTES, One Week, April 21
VAGINAL APPROACH TO PELVIC SURGERY, One Week,
March 24
BASIC COURSE IN OBSTETRICS, One Week, April 14
PERITONEOSCOPY, Two Weeks, March 17
ULTRAVIOLET CYSTOSCOPY, 1½ Days, March 24
ADVANCES IN UROLOGY, Two Days, March 25
PEDIATRIC UROLOGY, Two Days, March 27
ADVANCES IN SURGERY, One Week, April 28
ESOPHAGEAL SURGERY, Three Days, March 27
BASIC INTERNAL MEDICINE, One Week, April 14
BASIC ELECTROCARDIOGRAPHY, One Week, March 10
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Physicians Placement Service

(Continued from page 178)

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- 1** DIRECT THEM TO EMPLOYMENT OPPORTUNITY—by referring them to the Governor's Committee on Employment of the Handicapped.
- 2** BECOME AN ACTIVE FORCE FOR EQUAL EMPLOYMENT OPPORTUNITY IN YOUR COMMUNITY: Join your Local Council on Employment of the Handicapped.

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Louis A. Sabella
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on Employment of the Handicapped
Frank J. Jirka, M.D., Chairman
188 W. Randolph St. / Chicago, Ill. 60601
(AC 312) 372-3437

BLUE SHIELD REPORT



FOR *Illinois Physicians*

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March, 1969

Blue Cross and Blue Shield Sponsor Coordinated Home Care Program

Our sponsorship of a Coordinated Home Care Program is another way by which we are making it possible for physicians to discharge their hospital patients when they believe that patients will benefit from care at home rather than in the hospital.

The attending physician decides when his patient may be referred into our Coordinated Home Care program and continues to be in charge of his patient's care.

The program may be put into effect when it is approved by a Blue Cross participating hospital, its medical staff, and a home nursing agency. Payment for the cost of medical and nursing services received by the patient at home would be paid by Blue Cross and Blue Shield.

Payment may be made for laboratory tests, drugs, dressings, medical supplies, oxygen, and for the attending physician when he treats the same condition for which the patient was hospitalized. The attending physician's services in the home of the patient or in his office are paid for by Blue Shield on the Usual and Customary fee basis.

Fourteen hospitals in Cook County already are participating in this new program and other hospitals and their medical staffs are taking steps to get programs underway.

For a patient to be eligible for benefits he must be referred into the Home Care program by the attending physician, need nursing services and continued hospital services or supplies prescribed by the attending physician. The patient must have in-hospital benefit days and services and visits for physician's services still available under his Blue Cross and Blue Shield certificate and be discharged from a hospital participating in a Coordinated Home Care program. To be eligible, the patient must also require care which is directly related to the condition for which he was hospitalized, and which can be provided at home under the direction of his own physician.

Our new program now offers the physician the opportunity to discharge his patient earlier when he can return safely home under medical supervision. The patient benefits by returning to familiar surroundings. The hospital benefits by having a bed available for other patients in greater need of in-hospital services.

Blue Cross and Blue Shield do not operate Coordinated Home Care programs but will pay benefits for eligible members who are admitted into an established program by the attending physician.

For more information on how to start a Coordinated Home Care program in your community at your hospital, contact Miss Helen Wright, Director, Coordinated Home Care, Blue Cross and Blue Shield, 222 North Dearborn Street, Chicago, Illinois 60601.

Blue Shield Dinner-workshops For Medical Assistants Begin

Our regularly scheduled Blue Shield dinner-workshops for medical assistants begin April 9 at Mt. Vernon, Illinois.

This is the twelfth consecutive year Blue Shield has sponsored dinner-workshops for medical assistants. The workshops provide assistants the opportunity to ask questions relating to Blue Shield procedures and allow us to inform them of ways we can help in carrying out their responsibilities with their physician-employers.

Invitations will be mailed to medical assistants in care of their physician at his office address.

The subjects to be discussed will include Blue Shield's new out of hospital diagnostic protection, our Usual and Customary fee program, and the new Usual and Customary Blue Shield plan selected by Federal Employees which became effective the first of the year.

Following the discussion of these subjects, time will be allowed to answer questions from the audience who is urged to participate.

Dinner-workshops will continue through the month of June and have been scheduled, in part, as follows:

Wednesday, April 9	Mt. Vernon
Thursday, April 10	Marion
Wednesday, April 23	Belleville
Thursday, April 24	Edwardsville
Thursday, May 1	Effingham
Wednesday, May 7	Champaign
Thursday, May 15	Springfield

Starting in August, dinner-workshops will be scheduled in the Counties of Cook, Kane, Lake, Will, and DuPage.

If your office assistant has any questions regarding this or other Blue Shield matters, please contact Mrs. Loretta O'Donnell, 222 North Dearborn Street, Chicago, Illinois 60601.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Q How is a hospital based pathologist or radiologist paid for services they render to inpatients of a qualified hospital?

A Since March 31, 1968, a physician in the field of pathology or radiology is paid 100% of reasonable charges for his professional services to an inpatient of a qualified hospital whether he bills the Medicare patient directly or the hospital bills on his behalf.

Q Does the 100% reasonable charge provision apply when a hospital based pathologist or radiologist renders services to a Medicare inpatient of a qualified hospital other than his base hospital?

A Yes. Payment will be made as long as the service is rendered by a physician in the field of radiology or pathology to an inpatient of a qualified hospital.

Q How is a hospital based pathologist or radiologist paid for services rendered to outpatients or to patients that have been referred? Does it make a difference if he or the base hospital bills for the services?

A Physicians' services (including radiology and pathology) rendered to Medicare outpatients and to patients that have been referred are just as they were prior to March 31, 1968, i.e., the charges are subject to the deductible and 20% coinsurance. The manner of billing does not affect coverage.

Q When a pathologist or radiologist operates his own laboratory in a hospital and bears some or all of the costs of the operation, can the entire charge for inpatient pathology or radiology services be paid at 100% when he bills the patient directly?

A Yes.

Q What method of reimbursement is applicable when the facts are the same as in the above question except that the physician bills the hospital for the services?

A When the hospital bills the patient for the services of the laboratory and some or all of whose costs of operation are borne by the pathologist, Part A and Part B allocation must be made. The portion representing identifiable services rendered to individual patients requiring performance in person services by the physician is reimbursed on a 100% basis under Part B and the remaining allowable expenses are reimbursed under Part A.

Q In regard to the above, would there be any difference in coverage if the pathology or radiology services are rendered to inpatients of participating hospitals other than the physician's base hospital and the physician bills patients directly?

A Pathology or radiology services rendered by a pathologist or radiologist who bears all or part of the costs of operation of his laboratory to inpatients of participating hospitals other than his base hospital are covered at the 100% rate under Part B when the physician bills the patients directly.

Q When a pathologist or radiologist operates the hospital laboratory and bears some or all of the costs of operation and furnishes services "under arrangements" with a hospital, other than his base hospital, for its inpatients, what is the proper method of reimbursement?

A When a participating hospital obtains laboratory services "under arrangements" for its inpatients from the laboratory of another hospital, reimbursement is made under Part A.

Q What method of reimbursement is used for pathology or radiology services rendered to outpatients and referred patients when the pathologist or radiologist bears some or all of the operating costs of the laboratory located in a hospital?

A When outpatients and referred patients are billed directly by the physician, they are paid under Part B subject to the deductible and 20% coinsurance.

Q What reimbursement rule applies to radiology services furnished to inpatients of a qualified hospital by a nonhospital based radiologist when the radiologist bills the patients directly?

A The radiologist is paid 100% of reasonable charges. However, reading an X-Ray film as part of his usual services by an attending physician or surgeon would normally be 80% of the reasonable charge subject to the \$50 deductible.

Q Would there be a difference in reimbursement if radiology services were rendered to inpatients of a qualified hospital by a nonhospital based radiologist and he billed the hospital and the hospital in turn charged the patient?

A No. Reimbursement would still be under Part B at the 100% rate.

Q What reimbursement rule is applicable when the radiologist renders services to outpatients and office patients and bills the patients directly?

A The 100% reimbursement provision for radiology services applies only to inpatients of a qualified hospital. Services to other than inpatients of qualified hospitals are paid at the regular 80% rate less the deductible.

Q Does the 100% provision apply only when Part A hospital benefits are payable?

A No. The 100% reimbursement provision applies to the physician's charges as long as the individual is an inpatient of a qualified hospital and has Part B coverage.

Abstracts Of Board Actions

Meeting January 11-12, 1969—Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

BUDGET FOR 1969 UP ONLY 1%

The 1969 ISMS Operating Budget, which allows an increase of less than 1% in operating expenses against a 4.2% increase in the cost of living, was discussed at length. Every account, after thorough review by the Board, was individually acted upon. The budget was approved. No reduction in ISMS services will be necessary.

A report by the American Society of Association Executives regarding ISMS operating ratios in comparison with 46 other regional, state, and local associations which have primarily professional and individual members indicated that ISMS is in line with other comparable groups.

In addition, ISMS received a clean bill of health from the IRS after the audit of the 1966 and 1967 transactions.

NEW ADVISORY COMMITTEE TO DVR RECOMMENDED

In keeping with the Board's request of last October, a suggested advisory committee to DVR was nominated. It is anticipated that this committee will function in a manner similar to the Advisory Committee to IDPA. This will enhance the working relationship between the physician and the Division. Subject to the approval of the Division of Vocational Rehabilitation, the men suggested for the committee will be notified and asked to begin their duties.

TRUSTEES ASKED TO ANALYZE COUNTY SOCIETIES

Dr. Edward Cannady, ISMS president-elect, suggested that all Trustees list, in writing, the strong and weak points of each county medical society in their district and submit a report. He stated that the reports could be limited to one paragraph. This is to be done in an effort to strengthen each county society.

USV TO SPONSOR POSTGRADUATE SEMINAR

A request from the United States Vitamin Products Corporation for permission to sponsor a postgraduate seminar on peripheral vascular disease, in the Chicago area, was approved. USV will pay all the expenses for the meeting to be held in September, 1969. The seminar will be under the sponsorship of ISMS with the consultation and guidance of the proper committee.

ILLINOIS EMERGENCY SERVICES STUDY COMMISSION

The Ad Hoc Emergency Services Study Commission of Illinois is studying several phases of emergency care. The commission, created for the purpose of solving the threatened shortage of ambulance services in rural areas, has drafted several pieces of proposed legislation which the ISMS delegation has referred to the ISMS legal counsel and Legislative Council for recommendation.

(Abstracts continued on page 345)

The president's page



Philip G. Thomsen, M.D.

A GAUNTLET TO THE MED SCHOOLS

Fellow Illini:

I shall talk to you today about a grave and urgent problem. It's a problem that demands the most of us—of you and me. It cannot be solved by a bolt from the blue or by any form of magic.

I was reminded of its magnitude a few weeks ago, when a young reporter on a newspaper readers' service called the Illinois State Medical Society. He said a small town in western Illinois had lost its only physician. Could we quickly provide a replacement? Could we help the readers' service column bring Christmas cheer?

He seemed to lose all of his hope—and maybe some of his youth—as we outlined the cold, hard facts. Our Placement Service had listings of some 150 towns that desperately needed doctors, we told him.

Many experts know how widespread the crisis is, but lack this youth's eagerness to meet it headon.

Where is the hangup?

Are we in organized medicine limiting the production of doctors, in the fashion of a restrictive trade union? Of course not! Organized medicine is deeply upset about the shortage, and demands action.

Is there a lack of young men and women with the technical proficiency for medicine? No, the ranks are filling in other demanding skills.

Are government health programs and the Vietnam War causing the shortage? Partly—but other nations with government health programs are well stocked with doctors and are exporting some to us.

Then what is the chief cause of our shortage?

Gentlemen, I'm looking at it!

Our universities and medical schools have hemmed, hawed and dawdled on this problem—and let it grow into a crisis.

THE PROBLEM

We must see the physician shortage problem as an emergency. We must see it as the red domelight on an ambulance—not as an ivory tower.

We must cut through the red tape and the mounds of white paper . . . the endless conferences . . . the exhaustive studies, and reports on reports. We must convert long-range plans into quick action.

The medical crisis doesn't respect the academic courtesies . . . it's clamoring at our doors—**NOW!**

Illinois is short at least 7,000 physicians . . . **now.**

Twenty-seven of our county seats are without doctors.

Ten per cent of our state's residents

(Continued on page 304)

(Ed Note: Because of the impact made on audience and public officials, the President's Page this month is given over to the speech President Philip G. Thomsen made at the conference of University of Illinois Medical College alumni and faculty January 18 in Peoria.)

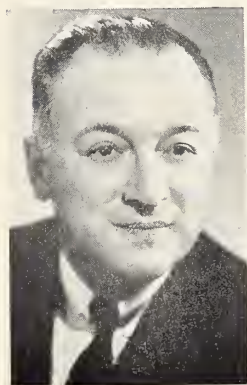
Recent Advances in The Treatment of Parkinsonism

BY BENJAMIN BOSHES, M.D., PH.D. AND JOEL BRUMLIK, M.D., PH.D./CHICAGO

With the growth of the geriatric medical population, parkinsonism has become an increasing rather than a decreasing problem. Therapy for this syndrome may be divided into four categories: drugs, physiotherapy, neurosurgery and treatment which engages the motivational and psychological aspects of the patient. Manifestations and progression of the symptoms vary greatly in a large group of patients. Hoehn and Yahr pointed out that in two-thirds of all patients (in their series) had the onset of the illness between the ages of 50 and 69.¹⁵ Men did not differ significantly from women and there was a gradual shift to an older age distribution. Approximately 25% of those who had the disease for less than five years were disabled or dead. At five to nine years this figure

had moved to 66% and reached 80% at the 10 to 14 years duration point. However a small group remained, patients whose disease had evolved slowly and who were not disabled after 20 or more years. The rate of progression of the disease did not seem to correlate significantly with the age or sex of the patient, the age at onset of the disease, a family history of parkinsonism or the presence of other neurologic involvement.

Tremor seemed to be the most frequent initial symptom, but this is the most obvious clinical manifestation to the patient. Contrary to popular opinion, having parkinsonism appeared to shorten life and did not protect the patient against malignant disease. However, the relative mortality risk was less for men than for women and



Benjamin Boshes, M.D., Ph.D., (left) is Professor and Chairman, Department of Neurology and Psychiatry, Northwestern University Medical School. He is also chairman of the department of Neurology and Psychiatry, Wesley Memorial Hospital, and consultant in Neurology at the V.A. Research Hospital and at Hines and Downey V.A. hospitals. He received his M.D. and his Ph.D. from Northwestern, serving an internship at Cook County. He has authored over 100 items relating to his specialty. Joel Brumlik, M.D., Ph.D., is associate professor of Neurology, Northwestern University Medical School. He also holds his M.D. and Ph.D. from Northwestern. Dr. Brumlik is on staff at Wesley Memorial Hospital and is a consultant in Neurology to the Dixon State School.



less for those whose primary disability was tremor. A disheartening note is that there was no evidence that the introduction of the newer methods of medical or supportive care had substantially prolonged life. The most frequent causes of death were broncho-pneumonia and urinary tract infections.

In any evaluation of the results of treatment in patients with parkinsonism, several factors must be borne in mind. This is not a disease with a fixed pattern, but rather a cluster of symptoms and signs which vary from patient to patient. Thus the definition of a "good result" for any therapy depends to some extent upon the problem presented by the person affected. Benefit thru treatment in one area may be followed by worsening in another. A common example is the improvement in tremor which may come in the wake of certain neurosurgical procedures but which may be accompanied by increasing slowness of movement and/or deterioration of speech and mentation. The net gain in such cases is nil. Secondly, having Parkinson's disease is not to be rigidly correlated with disability. It is not infrequently observed that some patients with parkinsonism will be disabled by a minor objective symptom such as tremor; others, though manifesting far more signs such as rigidity, tremor and slowness of movement, are able to go about their occupations for many years in a relatively normal manner. Thus, the treatment of parkinsonism is directed at a set of symptoms and signs, rather than at the disease per se; treatment is symptomatic rather than curative. It is often stated that patients with parkinsonism who have been operated on neurosurgically, are "cured." Actually the patient is given a period of "grace" during which certain symptoms appear to remain stable or to improve. After a variable period of time, from months to years, the symptoms worsen again so that the downhill course is resumed. Finally, the worth of any treatment must be judged in terms of whether more than one form of therapy is being given at the same time. For example, neurosurgical procedures, such as thalamotomy, are commonly followed by a period of intensive physiotherapy, coupled with antiparkinson medication. Which treatment is producing the effect, or are all

playing a role? In drug therapy the placebo effect cannot be discounted.

Recent Therapy Advances

For many years medication has been the standard form of treatment. The exact mechanism of action of these drugs is still unknown. On the one hand an anticholinergic antagonistic mechanism has been postulated, and another more nonspecific effect directed primarily at the motivational and psychic aspects of the illness has been described.^{8,12}

For purposes of discussion, the standard drugs may be divided into three classes, each aimed at one of the three cardinal symptoms: tremor, rigidity and bradykinesia, or slowness of movement. The drugs used in the management of tremor are the solinaceous alkaloids, or the atropine series. The oldest, hyoscine (scopolamine) is a naturally occurring substance. The synthetic drugs have received wider attention in recent years. These include trihexyphenidyl (Arthane), benztropine (Cogentin), procyclidine hydrochloride (Kemadrin), cycrimine hydrochloride (Pagitane), caramiphen (Panparnit), ethopropazine hydrochloride (Parsidol), and biperiden hydrochloride (Akineton). All are similar in that overdosage will cause significant and sometimes serious parasympatholytic side-effects, dry mouth, blurred vision, mental confusion, dysphagia, urinary retention, dizziness, nausea and constipation. They must be used with caution in cases of incipient or overt glaucoma. Drugs used in the management of rigidity are the so-called muscle-relaxant drugs such as Meprobamate (Miltown, Equanil) and the antihistaminic series such as diphenhydramine hydrochloride (Benadryl), chlorphenoxamine hydrochloride (Phenoxene), orphenadrine hydrochloride (Disipal). The analeptic drugs are useful in the management of akinesia. These include methylphenedate hydrochloride (Ritalin) and the amphetamines such as Dexedrine. The drugs used for rigidity may cause drowsiness and confusion in high doses and those given for akinesia may produce nervousness, dizziness, nausea and anorexia. The total benefit achieved with any one drug depends upon the therapeutic effect minus the undesirable side-effects. For example, tremor may be reduced by high doses of Artane, but if the patient becomes confused and disoriented

the net effect is worthless. These considerations apply even more aptly to the elderly patient.

Thus the medical regimen will consist of drugs directed at the presenting symptoms. This presupposes an accurate medical and neurologic evaluation to assess the degree of disability imposed by each of the cardinal signs. It is common to find that patients will complain bitterly of tremor, since this is the symptom which directs their attention to the illness and indeed prompts them to seek medical help. However, on examination, one often finds that it is not the tremor but the rigidity and akinesia which, in reality, prevent the patient from carrying out activities of daily living and enjoying a normal existence. One need only consider that the tremor of parkinsonism is a resting phenomenon which in two-thirds of the cases ceases on intentional motion. This symptom does not often interfere with activities such as eating, dressing, and the like. The most disabling features include the stooped posture, slow shuffling gait, immobility and freezing. These in turn lead to a variable degree of dependence upon others for aid in eating, dressing and the like. Such symptoms, rigidity and akinesia, respond only to a minor extent to the drugs of the solanaceous series.

In the elderly patient it is prudent not to begin with atropine-like drugs for two reasons: first, tremor does not constitute the disabling symptom and second, these drugs will often produce significant degrees of confusion and other undesirable side effects. We have been more successful in the treatment of parkinsonism in the elderly by stopping medication of this nature, rather than by adding additional drugs. For cases with severe rigidity, Phenoxene, Disipal and Benadryl seem to be the drugs of choice, and for akinesia, Ritalin or Tofranil (imipramine).

Certain psychological and motivational aspects of drug therapy may be examined. We have shown that the subjective opinion of the patient in regard to his improvement does not parallel objective measure of such betterment.⁸ In a double-blind study utilizing Artane and placebo, we found that tremor, rather than rigidity and akinesia, is benefited, to some extent. Ten patients in our series complained of side-effects such

as confusion, dry mouth and blurred vision while on Artane, whereas 12 patients reported identical symptoms while on a placebo. This only serves to point up the confused sophistication of patients with long-term chronic illnesses who have received medication in the past and who are allegedly aware of the effects and side-effects of such drugs.

Most Recent Chemotherapy

The most recent substance in the area of medication for parkinsonism is the drug known as L-Dopa. In 1960 Barbeau, following Hornykiewicz' report of a biochemical disturbance in parkinsonism, hypothesized that the metabolism of the catecholamines, more specifically dopamine, is probably directly involved in the extrapyramidal disorders of movement.¹ Two main possibilities occurred to him, either that the biochemical disturbances were related in a cause and effect relationship to the motor disorders, or, alternatively, that the chemical disturbances were a result of the symptoms. Many had reported that there is a diminished concentration of dopamine in the basal ganglia of patients with parkinsonism. This led Birkmayer to suggest that a decreased formation of dopamine may be causally related to the illness.⁴ It is interesting that in cases of hemiparkinsonism dopamine is diminished only in the contralateral basal ganglia. A similar hypothesis was proposed by Hornykiewicz,¹⁶ Bernheimer and Hornykiewicz³ and Barolin et al.² Various degradation products of dopamine metabolism, such as vanilmandelic acid and homovanillic acid had been found in increased quantities in the urine of patients with parkinsonism.^{19,21} This suggested a defect in dopamine metabolism, perhaps a lowered activity of tyrosine.⁶ This would lead to a decreased formation of dopa, dopamine, noradrenaline and adrenaline. It was therefore a logical corollary that administration of L-Dopa, the metabolite next in sequence from tyrosine, might be effective in raising the dopamine concentration in the brain and thereby lessen the symptoms of the illness.

Indeed, akinesia has been reported to lessen in 20 to 50% of cases after the administration of this drug.^{5,6,11,22,23} Discordant notes have been sounded by Rinné et al., in 1967 who found no differences between patients with parkinsonism and controls in

the excretion of VMA and HVA.²⁰ A similar finding was made by Nashold and Kirshner.¹⁸ Fehling found saline equally as effective as L-Dopa in relieving the akinesia of patients with parkinsonism.¹³ However this area of investigation is still in its infancy and further clinical trials are indicated.

Surgical Treatment Discussed

The neurosurgical treatment of parkinsonism dates back many years when various portions of the nervous system were attacked in order to relieve the symptoms. Prior to 1950, however, these efforts were only sporadic and the results not encouraging. In the last two decades, Cooper and co-workers, and later, hosts of others, have published widely on the results of neurosurgical ablation of various thalamic and striatal nuclei. In 1960, Cooper and Lin reported 100 consecutive patients over 60 years of age with parkinsonism who were operated upon over a period of 18 months.¹⁰ They claimed virtually complete relief of contralateral tremor and rigidity as well as bradykinesia in more than 75%. However, they cautioned that a good result depended greatly on the pre-operative selection of the patient. In 1963, Cooper stated that the lesion most effective in relieving the symptoms of parkinsonism was in the ventrolateral nucleus of the thalamus involving the posterior ventrolateral and posterior ventromedial nuclei. This lesion interrupted the pallido-thalamic radiations, corticothalamic circuits, and intrathalamic connections.

By 1966, Cooper and his group were able to report on over 5,000 individuals who had undergone surgery for the relief of parkinsonian tremor and rigidity.²⁴ Again, a most important factor appeared to be selection of the patient preoperatively. For example, age was found to relate directly to mortality, the recurrence of symptoms, and postoperative confusion. Hypertension and diabetes, the magnitude of pre-operative tremor and rigidity and especially prolonged illness and akinesia were directly related to adverse effects in the postoperative period. It is worth quoting from this study, "The results and risks for a person who is 40 years of age with unilateral tremor and rigidity and little in the way of impaired functional activities cannot be

equated with those of a parkinsonian 70 years of age with bilateral involvement and marked functional deterioration." Markham and co-workers agreed that akinesia was not changed by operative interference and probably has a different anatomical and physiologic substrate than tremor and rigidity.¹⁷ Other variables which affect the neurosurgical procedure were considered by Brumlik, et al., in 1964.⁸

Our own studies of the long-term effect of selected patients for surgery for parkinsonism would indicate that these patients only appear to be "cured." Examination reveals that while the amplitude of the tremor is reduced by the surgery, it rarely approaches normalcy. The frequency is usually the same, the parkinson rhythm of 4-6 per second. Sometimes there is a slight improvement for a while in the patient's ability to move, particularly walking, but this slows down again over time, as would be anticipated in the course of the disease. Even patients with unilaterally placed lesions in the thalamus have a 25% reduction in voice volume. Those on whom bilateral lesions are produced face a serious risk of developing so-called akinetic mutism or loss of ability to speak out. Thus surgery alleviates some symptoms, but never erases the significant features of the disease. Therefore the term "cured" is of ill-advised usage here.

Of all variables which affect the neurosurgical outcome, we too have also been most impressed by proper selection of the patient who is to undergo surgery. The ideal candidate appears to be a young patient, preferably under 50, with unilateral parkinsonism, whose primary disability is tremor rather than akinesia and rigidity. There should be no overt psychotic manifestations and no dementia. If this type of patient undergoes thalamotomy, he will more than likely have an excellent result regardless of the technique employed relative to the size, site and nature of the lesion. The latter vary as widely as neurosurgeons and neurosurgical centers. We must face the fact however, that the elderly patients with parkinsonism far outnumber the younger. Indeed, it has been estimated that 90% of patients are elderly, have bilateral manifestations, little in the way of tremor, and are disabled primarily by rigidity and akinesia. In these individuals, especially if there is intellectual de-

compensation in the form of mild to moderate dementia, or an accompanying psychosis, surgery may not only be ineffective but may actually worsen the patient, either in the form of markedly increased akinesia, increased dementia, or total mutism. It is for this type of patient that surgery constitutes a significant hazard and should be avoided.

Rehabilitative Physiotherapy

Physiotherapy is the keystone of treatment for those patients with parkinsonism who are disabled primarily by rigidity. The problem may be confined to the trunk, so that evaluation of the arms and legs by the standard passive range of motion maneuver may fail to elicit the significant disability. A patient with a stooped, shuffling gait, who rises from the chair only to freeze, who cannot turn, who has retropulsions, festinating gait, and who plumps into his chair, most likely has a significant degree of truncal rigidity. Passive movement of the trunk, either in bending forward or backward or in lateral rotation, will elicit this limitation. An active program of physiotherapy may be more effective than medication in relieving the patient. Passive range of motion exercises to all extremities and trunk, hydrotherapy and massage, done on a daily basis in the hospital or extended care facility, or two to three times a week on an outpatient basis; is of value. The intelligent, cooperative patient soon learns the amount of physiotherapy required to control his symptoms, and therefore develops a home program of such activity which will maintain him at maximum functional level. It is often true that the patient with parkinsonism becomes embarrassed and discouraged by symptoms which seem to separate him from his fellow man. He becomes a recluse, a state of affairs which only adds to his depression and feelings of worthlessness. In a vicious circle, these attitudes cause immobility and increase muscle rigidity with consequent deterioration of motivational state. A strong positive attitude on the part of the physician and an active program of physical therapy are helpful, not only from the physical but also from the psychological standpoint. In addition to passive range of motion exercises, active exercise, if tolerated, is also indicated, especially swimming

and bicycling. Each program must be tailored to the needs and abilities of the individual. The two factors most important in this regard are the age of the patient and the initial degree of his functional disability. Obviously, with improvement he will be able to do more and this will lead to further improvement.

Mental Attitude of Patient

Already alluded to are the motivational and psychological aspects of the illness. It is the rule rather than the exception for the patient with parkinsonism to develop significant degrees of depression and paranoid ideation. Such symptoms are entirely separate from the dementia, which may be an accompaniment or a consequence of any illness in the elderly. Either may occur alone, or both may be present. Indeed, if no such manifestations are evident one will always be impressed with the suggestibility and the role of tension and excitement in the patient with parkinsonism. It is a common observation that the tremor of patients with parkinsonism disappears in sleep. This is also true of the rigidity. It has been shown (Boshes, et al.⁷) that this waning of tremor amplitude and incidence is related not so much to sleep *per se*, but rather to the amount of goal-directed attention employed by the individual at the moment. Everyone has remarked on the patient with parkinsonism who, relaxed and sitting undisturbed, has no tremor, only to develop a wild oscillation when addressed. We have elucidated the physiologic correlates of this phenomenon. In sleep, with no electroencephalographic alpha rhythm, the patient with parkinsonism has no tremor. On arousal, alpha waves come in. However, the tremor does not make its appearance until there is desynchronization of the alpha rhythm, as in attention. It is interesting to speculate on the role of the ascending reticular activating system in the production of wakefulness and on the place of the descending reticulospinal tract and gamma motor system in the production of rigidity and tremor.

This raises a question, then, as to whether the effect of medication and indeed physiotherapy, is not primarily psychological rather than organic-pharmacological. The question is difficult to answer. Patients have made remarkable improvement on placebo,

both on oral medication and when saline has been injected into the motor point of the muscle. One of our studies concerned the histology of the motor endplate in patients with parkinsonism. After biopsy of an upper extremity muscle, one patient lost tremor completely in the limb for six months and begged to have the other side operated. During one procedure for thalamotomy, only a skin incision was made and the operation stopped due to complications arising at the moment. However, the patient lost tremor on the contralateral side for three months. These vignettes serve to underline the profound effect of the psyche and motivational factors on the illness. This has led us to manage many patients with parkinsonism with the antidepressant drugs such as imipramine (Tofranil) or amitriptyline (Elavil). Tofranil, in appropriate doses, is almost as successful in some cases as the solanaceous alkaloids or the antihistaminics. It may be used alone or in combination with other drugs, as the situation dictates.

In certain patients who become profoundly depressed, electroconvulsive therapy has been required. We must remark on the profound and dramatic effect of this treatment on the symptoms of parkinsonism. Concomitant with the procedure, the evidences of parkinsonism all but disappear, so that the patient appears nearly normal. One must emphasize, however, that this occurs during the period of confusion, and the effect of relaxation and in-

attention on the symptoms may be significant. Indeed, as the patient clears and remembers his former state and the illness, the symptoms tend to recur.

The patient with parkinsonism must be properly evaluated neurologically and medically in order to assess not only the objective signs of the disease, but also those which are causing the disability. Each patient with parkinsonism is an individual and may manifest various shades and combinations of tremor, rigidity, akinesia and psychic change. Only by meticulous evaluation and investigation of these several components can the physician arrive at a rational approach to therapy. In a young patient with unilateral parkinsonism, primarily tremor, with little rigidity or akinesia, and in whom all medical therapy has failed, a neurosurgical approach may seem warranted. In the elderly patient with rigidity and akinesia, mental changes and depression, drug therapy and physiotherapy in varying proportions will be advisable, but the motivational and psychiatric implications must not be neglected.

Thus, the advances in the treatment of parkinsonism in the past few years have been concerned not only with the development of new chemotherapeutic agents such as those related to dopamine metabolism, but have emphasized that the management of a given patient depends upon meticulous address to each of the components of his disease.

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A Form of Group Practice

"From the consumer's viewpoint, many years of experience with a middle-class clientele attest to the fact that this group practice arrangement is providing something for which the public is willing to pay. Despite some inconveniences inherent in an institution oriented toward teaching and research, every increase in the facilities during their 40-year history has been promptly followed by an increase in the patient population. About 20 per cent of the patients are referrals from neighboring physicians. The remainder, who constitute the bulk of our patients, come expecting the clinics to become their personal physician. They apparently accept the fact that they have more than one physician, and that in the absence of the particular doctor who normally attempts to provide continuing care, there are others who are acquainted in a general way with the problem. They develop confidence that the young physicians in training accept responsibility for important decisions only after consultation with a supervising faculty member. Although home visits are rarely made, they are aware that the emergency room is their physician's front door, and that through it, all the facilities of the institution are available to them.

This responsible group of paying patients expects and receives courteous and respectful consideration from all members of the clinical staff. Working closely with the members of the faculty who are accepting responsibility for patient care in both the clinic and hospital service, the student sees a variety of different individual methods of practice and many examples of devotion to the care of the ill in situations in which no financial reward accrues to the physician for keeping the patient satisfied and well." (Speech by Dr. Leon O. Jacobson, Dean, Pritzker School of Medicine, at the New York Academy of Medicine Conference on Group Practice.)

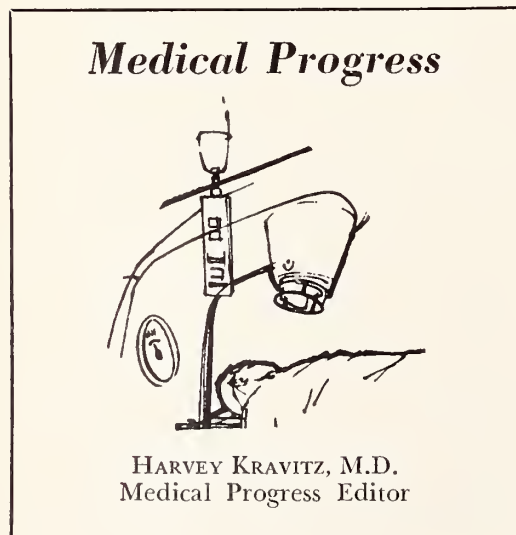
Convulsive Disorders In Infants and Children

BY HERBERT J. GROSSMAN, M.D./CHICAGO

Convulsive disorders represent a major medical problem in infancy and childhood. Over the years there has been considerable medical interest and study of seizures. This short review does not attempt to summarize general information about convulsive disorders; basic knowledge is assumed. We shall attempt to highlight certain new insights and research contributions of the past few years.

There has been no major "breakthrough" in our understanding of the etiological factors causing convulsive disorders, nor can we clearly delineate the specific neurological "malfunction" which may precipitate a specific attack. Epilepsy may represent a variety of abnormal processes in the brain, in combination or singly. Some of these abnormal variations may be structural, others chemical or metabolic and others "idiopathic." We do know that we are dealing with a complicated, multi-faceted problem of neuronal organization and functioning. In addition to the multiplicity of etiologic and pathologic factors in convulsive disorders, specific types of seizures also reflect the complicated processes of growth, maturation and senility. The wide array of clinical manifestations which we see at different ages is, in part, due to developmental changes in cerebral anatomy and physiology, as well as to the different pathologic processes necessary to produce seizures at various ages.

Infants and small children generally do not present the classic type of seizure described for older children and adults. Seizure activity in infants reflects the immature state of the central nervous system. These convulsions are rarely organized, generalized seizures; they are often multifocal with strong tonic components. Clonic seizures are infrequent during the first few



years of life. We seldom see the "classic" grandmal or psychomotor seizure in young children, while the typical petit-mal seizure is uncommon in early infancy.

Febrile Convulsions

Millichap (1968) has presented an extensive and timely review of this problem. Febrile convulsions may occur as a complication of infection and fever even though the disease process does not involve the central nervous system. This is the most common type of seizure in infants and young children. This disorder affects an estimated one-half million children in the United States. Thirty percent of all children having seizures have this type. Males have a somewhat greater incidence of febrile convulsions than females, and white infants are more frequently affected than Negro infants, although causal factors have not been delineated. The peak incidence for febrile convulsions is the age period between six months and three years. Ninety-five percent of these children have their first seizure before the age of five years. There is a family history of febrile convulsions in about 17% of the cases and a family history of some type of epilepsy in an additional 15%, indicating a possible genetic factor. There is suggestive evidence of birth trauma (primarily anoxia) in approximately 17% of the patients.

Fever preceding a febrile convulsion is caused by an upper respiratory infection

in 60% to 70% of the cases although fever may also be associated with gastro-enteritis, pneumonia or bronchitis. A common misconception indicates that febrile convulsions are associated with very high fevers. In fact, susceptible children may have a seizure when fever reaches the range of 102-104 degrees. The rate of the rise of the fever is not particularly relevant nor does the infectious process per se have a specific role in precipitating the seizure.

The manifestations of the seizures will vary. About 86% of the patients will have generalized seizures; with 80% having clonic manifestations; and an additional 11% with focal involvement. In the majority of cases, (76%) duration of the seizure is less than 20 minutes; only 2% last more than one hour.

Abnormal neurological signs are seen in about 4% of the cases while 9% of patients with febrile convulsions may have some degree of mental retardation. Laboratory investigation of febrile seizures reveals very little other than the identification of the specific infectious agent.

The electroencephalogram usually does not record any specific abnormal patterns. Aberrant EEG patterns are more common when febrile seizures occur in children over five years of age. There is also a greater possibility that they may develop paroxysmal seizures. Paroxysmal discharges recorded by the EEG occur more frequently with prolonged convulsions. The occurrence of prolonged convulsions and an abnormal EEG 10 days after the onset of the first seizure suggest the strong possibility of recurrence.

The prognosis in febrile convulsions is generally good. Permanent brain damage is rare; less than 2% of patients have residual damage. Febrile convulsions are likely to recur in about 44% of the cases. When the patient has only one febrile convulsion, a generalized seizure not associated with fever may occur later in about 6% of the cases. However, 50% of the patients having four febrile convulsions will have a subsequent non-febrile convulsion.

Treatment of febrile convulsions is usually managed by the administration of phenobarbital and aspirin. The subsequent goal is the prevention of another seizure. There are two prevailing and conflicting opinions regarding prophylaxis. The first suggests



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intermittent medication; i.e., administration of phenobarbital as well as aspirin whenever onset of infection indicates possible danger of fever. The other proposal suggests that continuous anti-convulsant medication (phenobarbital, diphenylhydantoin) should be initiated, treating the single febrile convulsion in the same manner as we would the non-febrile seizure. The author supports continuous medication as the preferred prophylaxis. Continuous medication is particularly indicated if the initial convulsion is prolonged, (in excess of 20 minutes); if abnormal neurological signs are evident; or if there has been a history of one or more spontaneous non-febrile convulsions. Since febrile convulsions are most common in the pre-school years, medication is usually withdrawn at the age of six years and should be done gradually.

Probably the most important factor in diagnosis and medical management is that febrile convulsions must always be differentiated from seizures that may accompany some specific disorder, particularly those which may involve structural abnormalities of the brain, or those which are related to toxic and/or metabolic disturbances.

Petit-Mal Seizures

Petit-mal seizures are paroxysmal episodes characterized by lapse of consciousness with brief staring, often accompanied by rhythmic blinking. The child does not lose postural control and may resume his previous activity as if there had been no loss of contact. Occasionally, there may be twitching of the mouth or extremities or even sudden changes in posture. There may be autonomic manifestations such as flushing or palor, vomiting and abdominal pain. Sphincter incontinence is unusual. The automatisms common in psychomotor seizures are infrequently seen in petit mal. On rare occasions, there may be unprovoked attacks of laughter. Petit mal status occurs when seizures become almost constant, resulting in a disturbance of consciousness.

Petit mal seizures are noted primarily in children from six to twelve years of age, although they may occur as young as three. They are rarely seen in infancy and petit mal seizure activity often subsides clinically as well as on the EEG by adolescence.

A child with petit mal may have very

frequent seizures, which interfere with school performance. Such children are often thought to be day dreaming and this is the complaint which may cause the parents to seek medical help. These "absence" attacks may be precipitated by hyper-ventilation, a fact very practical in making a diagnosis during the clinical examination or during the recording of the EEG. Flickering light too may trigger these seizures in those individuals who are susceptible.

Children with petit mal usually do not have neurological abnormalities, although occasionally they may have "soft" neurological findings. They may have learning and/or behavioral difficulties. In general, patients with true petit-mal seizures do not have any significant impairment of intellectual abilities. Some recent studies, however, indicate that a considerable number of petit mal patients have borderline normal or lower than normal intelligence. This would seem to contradict the generally held view that these children with petit mal usually have average or higher than average intelligence.

Petit mal seizures are usually accompanied by a typical generalized and well organized spike and three cycle per second wave activity on the EEG recording. In some children grand mal seizure activity may be associated with the petit mal seizures. Sometimes this pattern may not be clinically apparent but present on the EEG, where a so-called "larval" grand mal component may be noted. In these cases, control of the petit mal seizures is often quite difficult and may require a combination of anti-convulsant agents.

Recent longitudinal studies of patients having petit mal seizures have broadened our knowledge of this disorder. Petit mal seizures can no longer be looked upon as a benign disorder. These studies indicated that grand mal seizures will appear in over fifty percent of the petit mal patients before the age of sixteen. These grand mal seizures are generally responsive to medication. Grand mal seizures are more likely to occur where there is poor control of the petit mal seizures, positive family history, and abnormal EEG activity, (in addition to the characteristic petit mal pattern). Grand mal seizures are also more likely in those patients whose petit mal seizures persist into adolescence. The tendency to develop grand mal seizures appears to be

less in those patients where petit mal seizures cease at an early age, where there is no familial history of epilepsy. Normal intelligence, (indicative of less extensive brain involvement), good control of the petit mal seizures with drugs, and an EEG with normal background activity indicate a more favorable prognosis.

Petit mal seizures generally can be treated with one of the "dione" drugs or "succinimide" compounds. It is important that the distinction be made between brief focal seizures and petit mal epilepsy.

Grand Mal Seizures

Grand mal seizures are generalized convulsive movements which may be tonic, clonic, or tonic-clonic. Prior to the generalized convulsion there may be an aura which is actually the beginning of the seizures. The auras may range from autonomic-like manifestations such as a feeling of dizziness, abdominal pain, nausea, vomiting, or various paraesthesias to *deja-vu* phenomenon. The aura may be unrecognized because of the rapidity of onset of the seizures. Classical seizures are characterized by a strong state of tonus which includes the muscles of respiration resulting in a forceful expulsion of air through the glottis producing a cry. The tonic stage is associated with generalized stiffening of the extremities and after a short period progresses into a clonic phase with rhythmic jerking, most evident in the extremities and face. There is loss of consciousness during the seizure. Bladder and bowel sphincters may be relaxed during the seizures and pupillary reflexes disappear. Bilateral extensor toe signs are common following the seizure. The actual seizure itself is followed by a post-ictal period during which the patient may have varying manifestations ranging from headaches to extreme lethargy or even a profound coma which may last from minutes to hours. Todd's paralysis is a temporary weakness of an extremity or one side of the face following a seizure and has localizing significance. During the seizures, the EEG records massive electrical discharges involving the entire subcortex and even the brain stem. These massive electrical discharges eventually are broken by periods of silence. Following these seizures, the EEG is characterized by much slowing.

Sensory Induced Seizures

It has long been known that sensory stimulation, particularly intermittent photic stimulation, may precipitate epileptic seizures. This has occurred when patients were in a situation that created intermittent photic stimulation such as observing the horizon from a moving vehicle. In recent years the majority of these seizures have occurred while a child is watching television, particularly if the set is defective or if there is a disturbance in vertical control. These attacks vary from petit mal to grand mal seizures and may have myoclonic components. Seizures may also be induced by sound or music or even tactile stimulation.

Infantile Spasms

Infantile spasms (infantile myoclonic seizures) are lightning-like seizures often resembling a startle reflex. These seizures can be multi-focal or generalized. In some cases all the extremities are involved; in other instances there is only a sudden flexion of the neck, the nodding spasm. Both the flexion spasm and the extensor seizure may be seen in the same patient at different times or as part of the same series of seizures. These seizures are often difficult to detect visually but they are often felt when the mother is holding the baby. They may occur with varying frequency; from several times a day up to several hundred times a day. The usual onset is about five or six months of age.

A concomitant problem is a severe degree of developmental retardation. It has not been determined in all cases whether the retardation results from the multiple and frequent seizure activity or whether the infantile spasms and the retardation both reflect a diffuse impairment of the central nervous system. The majority of these infants have a characteristic EEG abnormality called *hypsarrhythmia*. This is an extremely abnormal EEG pattern with poorly organized high voltage spike and slow wave activity appearing in all leads.

In some patients with infantile spasms, there is an identifiable disorder; in other patients one cannot determine the etiologic factor. The causes of infantile spasms are numerous, including metabolic derangements such as phenylketonuria, py-

ridoxine deficiency, infectious diseases such as toxoplasmosis, encephalitis, structural abnormalities such as tuberous sclerosis and certain degenerative nervous system disorders of infancy. The vast majority of infants with this disorder have considerable impairment of intellectual development. Treatment is of interest because the use of ACTH and/or steroids has been of value in many of these cases. On administration of these drugs, the EEG may often revert to a normal pattern although this is not necessarily associated with complete control of the seizures. Even with complete control of the clinical seizures, it is unlikely the mental development will be normal in most cases. The clinical seizures as well as the typical abnormal electroencephalogram sometimes subside by two to five years of age.

Petit Mal Variant Seizures
(Akinetic; minor-motor; salaam; jack knife; massive myoclonic seizures)

Petit mal variant seizures usually begin during the pre-school period, three to four years of age, and persist through the school age years. These seizures are characterized by a sudden nodding of the head, a jack-knifing of the body and a sudden loss of postural control. There may be loss of sphincter control. These seizures are usually of short duration and are often followed by post-ictal lethargy. The frequency of these seizures varies considerably, occurring once or twice a day up to several dozen times per day. These patients may also have generalized convulsions, either following a petit mal variant seizure or at other times. Many of these children have a concomitant problem of mental retardation. In addition, a large percentage of these children have other evidence of nervous system deficit with clear-cut neurological findings.

The EEG abnormality is usually a spike and 1 to 2 cycle per second wave activity that often has some polyphasic spike discharges intermixed. The pattern, although a spike and wave phenomenon, is significantly different from that seen in true petit mal. These seizures are generally very difficult to control and usually require more than one anti-convulsant agent. Control of these petit mal variant seizures is best attempted by utilizing drugs effective for

grand mal seizures rather than drugs used for the treatment of typical petit mal seizures.

Epileptic Equivalents
(diencephalic epilepsy; autonomic epilepsy; abdominal epilepsy; the 14 and 6 per second positive spike phenomena).

In recent years there has been a great deal of interest in the so-called "epileptic equivalents." This concern has ranged from well-planned medical research to a widespread public dissemination by the communications media of the more sensational behavioral manifestations attributed to these epileptic equivalents. Medical investigations have defined "epileptic equivalent" seizures with a common clustering of clinical manifestations. There is usually a paroxysmal onset, with or without a preceding aura. Sometimes there is the suggestion of an aura without further clinical manifestations. The patient may experience headache, syncope, nausea, vomiting, or abdominal pain. Flushing, circumoral pallor, sweating and changes in pulse and respiration may be noted. These manifestations may last from a few minutes to several hours. In some instances, the patient experiences loss of consciousness. The seizures may be followed by weakness, lethargy and/or sleep, suggesting a post-ictal phenomenon. These seizures are often diagnosed as diencephalic epilepsy; autonomic epilepsy, abdominal epilepsy, or the "14 and 6 phenomenon." Aggressive behavior has often been attributed to an atypical form of epilepsy. Recent studies have failed to show a specific correlation between behavioral disorders and the clinical manifestations more typically associated with convulsive disorders.

When the patient does present clinical manifestations of seizure activity, a trial of anti-convulsant medication is indicated. These seizures usually respond well to diphenylhydantoin and/or phenobarbital.

In some of the patients with this type of seizure the electroencephalogram has shown 14 and 6 per second positive spikes. This pattern is usually seen only during drowsiness or light sleep. It is more likely to be observed during monopolar rather than during bipolar recording of the EEG. The diagnosis of a convulsive disorder in

these cases should be based primarily on the clinical history of the seizure. A diagnosis based solely on the finding of 14 and 6 per second positive spikes without clinical manifestations should be seriously questioned.

Aggressive behavior as an isolated symptom is not a clear indication of a convulsive disorder. Indeed recent studies indicate that the 14 and 6 per second positive spikes are present in the EEG recordings of the majority of normal school-age children studied. Such studies indicate that this EEG finding is not specifically indicative of a seizure or behavioral disorder. In fact, recent studies have shown no clear-cut correlation between any specific EEG finding and behavioral disorders.

Psychomotor Seizures

Psychomotor epilepsy, as the name implies, has manifestations which reflect impairment of mental and/or motor function. The mental symptoms may consist of alterations of consciousness, fear, disturbances of thought and/or complex hallucinations. Common motor manifestations are gustatory phenomenon (masticatory and swallowing movements), simple or complex movements of the body, and stereotyped automatisms. Examples of these automatisms are such motions as fidgeting, pulling at the hands, picking at one's clothing, shuffling, or walking around purposelessly. There may be irrelevant speech and inappropriate behavior. These seizures may be preceded by an aura of varied sensory phenomenon. A feeling of anxiety may also be part of the aura. Psychomotor seizures are usually brief (one or two minutes). Occasionally a seizure may last several hours. The seizures are followed by post-ictal confusion, lethargy and/or sleep.

The clinical manifestations of aura, automatisms and post-ictal phenomenon distinguish the psychomotor seizure from petit mal. In addition psychomotor seizures occur less frequently than petit mal. The distinction has both therapeutic and prognostic significance. Many of these patients have varied behavioral difficulties in between seizures and may present hyperkinetic syndromes.

The EEG recording reflects a focal abnormality in the anterior part of the temporal lobe. In about one-half of the cases, psychomotor seizures are completely con-

trolled by anti-convulsant medication (Mysoline, Dilantin and phenobarbital).

Breath-Holding Seizures

Breath-holding seizures, or apneic spells, have a period of onset similar to febrile convulsions; that is, roughly between five or six months of age through about four or five years of age. The clinical manifestations of these seizures are often evidenced when the susceptible infant or young child has been frustrated or when the child sustains some minimum trauma following which he begins to cry, building up to a point of breath-holding followed by a period of apnea. During this episode he may become cyanotic, with loss of consciousness and loss of postural control. The episode generally does not last very long. In some instances, a generalized seizure is associated with the breath-holding. The EEG recording in these patients is almost always normal. Various studies have indicated that the prognosis for breath-holding seizures is quite good. These seizures apparently do not fall into the category of a true epileptic disorder. Anti-convulsant medication (phenobarbital, Dilantin) seems to be indicated only in those cases that have associated convulsive manifestations.

Treatment

Anticonvulsant medication is not required for all children with seizures. The specific etiology often determines management. In metabolic or endocrine disorders, neoplastic diseases and infections treatment is directed at the underlying cause whenever possible.

Anticonvulsant drugs are necessary in the great majority of children with recurrent seizures. Approximately 50% of the patients are seizure free with anticonvulsant agents and partial control can be achieved in an additional 25%. Unfortunately the use of some drugs which have proven successful in seizure control must be limited by serious side reactions.

Therapy with anticonvulsant drugs must be individualized. Grand mal, focal, Jacksonian and febrile convulsions are best treated with phenobarbital, Dilantin, Mysoline, Mebaral, alone or in combination. Typical petit mal responds best to Tridione, Paradione, Zarontin, Celontin and Milontin. Amphetamines, (Benzedrine and

Dexedrine) and Diamox are often valuable adjuncts in the treatment of petit mal seizures that do not respond well to other medication. Petit mal variant seizures respond best to the drugs used in the treatment of grand mal seizures. Control of these seizures is generally difficult. Infantile spasms may respond to ACTH or steroids in combination with drugs that are used to control grand mal seizures.

The ketogenic diet is of limited value. Bromides have little if any value in the management of these disorders and there is great potential for toxic reactions.

No major breakthrough in the medical management of convulsive disorders has occurred in recent years. Of interest are three areas of investigation that may prove of value. (1) The use of ACTH and steroids in the treatment of infantile spasms associated with the EEG abnormality of hypsarrhythmia has been discussed. (2) Anticonvulsant treatment has always been very difficult in infantile spasms and petit mal variant seizures. Recent reports on the use of an analogue of chlorthalidone hydrochloride called nitrazepam (Mogadon) in these disorders appears to be promising. However, side effects including drowsiness, ataxia, urticaria, provocation of grand mal seizures and dyskinesia may limit its use. The drug has not thus far been released for general use. (3) The treatment of status epilepticus remains one of the more difficult management problems in clinical medicine. Recent studies seem to indicate that diazepam (Valium) administered intravenously or intramuscularly may be of particular value when used as the initial drug in the treatment of a prolonged convulsion (status epilepticus). Further studies should be of much interest. The use of parenteral diphenylhydantoin sodium in the treatment of a prolonged convulsion has been evaluated over the last few years. There are varying opinions as to its effectiveness. Because of cardiovascular depression, it should not be used in patients with severe heart disease. Prolonged seizures occurring in patients with acute cerebral disorders remain very difficult to control. For a comprehensive review of anti-convulsive treatment, the reader is referred to references.

Surgery is of little value in the treatment of convulsive disorders. There are three possible indications for surgical in-

tervention: (1) In patients with infantile hemiplegia who have intractable seizures and uncontrollable hyperactive behavior, hemispherectomy is occasionally of value. However, a long term complication has recently been reported. Repeated intracranial hemorrhages may occur years after the hemispherectomy. (2) Uncontrolled psychomotor seizures may benefit from temporal lobectomy if there is evidence of a focal EEG abnormality. (3) Focal lesions, secondary to trauma, may result in seizures refractory to medical management. Occasionally the excision of the local lesion may be of value.

Medical management of epilepsy must include a consideration of the social and emotional factors which are extremely important in this long-term problem. If the seizures are well-controlled on medication, the patient's daily living does not need to vary significantly from that of the child without epilepsy. The child should remain in a regular school program. Special placement may be indicated for lower-than-average intellectual functioning—rarely for the convulsive disorder per se. The child should be encouraged to continue participation in a full program of physical and social activities.

For the patient whose seizures cannot be completely controlled on medication, life will be much more difficult. Every attempt should be made to encourage the child and his parents to live in a manner as nearly normal as possible. The physician may need to interpret the child's capacities and potentials as well as his limitations to the school and to the community agencies. Helping parents to understand and deal effectively with the realities of a convulsive disorder as a chronic problem as well as with their feelings about epilepsy is a very important responsibility for the physician. Such help is possible only with an accepting, understanding attitude on the part of the physician.

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MEDICINE IN THE SEVENTIES

ISMS Annual Convention

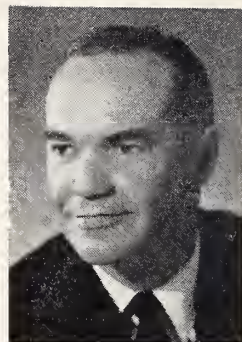
May 19-21, 1969

Sherman House, Chicago

EDITORIALS



OUR EDITOR



T. R. Van Dellen

It is with great pleasure that the *Journal* takes note of the fact that on April 1, 1969, Dr. Theodore R. Van Dellen will celebrate a 20 year association with the *Illinois Medical Journal*. Under his aegis the *IMJ* has become one of the leading state medical journals.

Two decades ago this month, Dr. Percy Hopkins entered a motion into the records of the ISMS Council (Board of Trustees) that Dr. Van Dellen assume the position of associate editor of the *IMJ*. Thus began a warm and dedicated term of service between Dr. Van Dellen, the Illinois State Medical Society, and the *Journal*.

An educator and writer, as well as a highly respected physician, Dr. Van Dellen has served the medical profession well.

The son of a Chicago physician, Dr. Van Dellen received both his B.S. and M.D. degrees from Northwestern University. Certified by the American Board of Internal Medicine, Dr. Van Dellen is an assistant dean and associate professor of medicine at Northwestern University Medical School and medical editor of the *Chicago Tribune*. His nationally syndicated health column, "How to Keep Well" has received as many

as 180,000 letters of inquiry from his readers in one year. Dr. "Ted" is known as one of the nation's top medical writers. He has been president of the American Medical Writers Association, is on the editorial board of the "Medical World News," and is an alternate delegate to the AMA.

In addition, Dr. Van Dellen has actively served as an officer and committee member in over 20 professional societies, as well as holding over a dozen academic positions.

In this era of ever-increasing scientific knowledge and progressively sophisticated communications systems, Dr. Van Dellen has helped the *Illinois Medical Journal* keep pace.

Dr. Van Dellen's awareness and sensitivity to the needs and interests of the members of the Illinois Medical Society has kept the *IMJ* from becoming "just another journal." Under his able direction, the *Illinois Medical Journal* has maintained its function as a progressive state medical journal "specializing in every specialty."

On this auspicious anniversary, we extend our appreciation and congratulations to Dr. Theodore Van Dellen.

The *IMJ* Staff

THE TELEPHONE AND THE PRACTICE OF MEDICINE

A group of physicians under the direction of Joel J. Alpert, M.D. have reported on a study of the use of the telephone by low income families offered comprehensive and continuing medical care.¹

The results of the study showed that low income families used the telephone to seek medical care and advice approximately as families seen in middle class private practice. There were significantly fewer visits

to the clinic as the patients in the low income group became more familiar with the use of the telephone. These patients did not make unusual or excessive demands upon their physicians.

There are several medical-economic advantages to the use of the telephone. The patient in the low income group is saved the expense of frequent trips on public transportation to the clinic. If a system of screening patients by telephone were carried out at teaching hospitals, their clinical facilities would not be overburdened, and the traditional long wait in clinics would be greatly reduced. Nothing can be more frustrating than the mother who brings a child to an overcrowded clinic and waits several hours when simple telephone advice would have sufficed.

The potentialities of the telephone in medicine have only recently been appreciated by medical schools and teaching hospitals. Despite the fact that the telephone is the prime means of conversation between the physician and patient, most medical students, interns and residents are given no instructions on how to accept telephone calls and give proper medical advice by means of the telephone. Medical educators have long viewed with disdain the use of the telephone to obtain or give medical information or treatment. The facts of life must be faced, however. Doctors in practice do give medical advice and treatment to countless patients by telephone.

It is logically impossible to see every patient that calls a physician by telephone. Indeed, the doctor who compels every patient who seeks medical advice and treatment to come to his office would be considered most unusual by his patients and his medical colleagues.

The greater use of the telephone for transmitting medical information can be

helpful, particularly where a severe shortage of physicians exists. Since the shortage is expected to continue for at least another decade, more attention should be paid to this means for transmitting medical information. Several years ago it was pointed out that the sounds of respiratory diseases such as croup, asthma, bronchiolitis and common colds could be transmitted by telephone.² With training, a physician could easily distinguish normal breath sounds from the sounds of respiratory diseases by having the mother place the mouthpiece of the telephone close to the patient's mouth. The value of this method as a teaching aid to medical students, interns and residents was emphasized. Another example of recent developments in the transmission of medical information by telephone has been the sending of electrocardiograms and electroencephalograms through this medium.^{3,4}

It is important for those governmental agencies who spend the tax dollar for the medical care of the economically disadvantaged groups of our country to evaluate the results of Dr. Alpert's study. It may result in significant savings to these programs and also be an aid in improving the delivery of good medical care to all segments of our society.

Harvey Kravitz, M.D.

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University of Illinois Medical Center Grants

The University of Illinois Medical Center Campus, Chicago, accepted an overall total of \$1,030,552 in research and training grants in the month of January. Out of 21 grants listed, 14 grants totaling \$877,648 were from the United States Public Health Service.

The funds were allocated as follows: \$141,772, College of Dentistry; \$828,994,

College of Medicine; \$20,768, College of Nursing; \$29,398, College of Pharmacy; and \$9,620, Student Affairs. The largest single grant, \$279,659, was awarded to Dr. William J. Grove, professor of surgery and dean of the college of Medicine, by the United States Public Health Service for "General Research."

Illinois Department Of Public Aid

Payment Procedures and Policies Explained

HAROLD O. SWANK, DIRECTOR
ILLINOIS DEPARTMENT OF PUBLIC AID

Part V of a Series.

In this fifth installment of the series on physicians' fees, discussion centers on how the physician requests payment for medical services rendered to a public aid recipient who is also covered by Medicare.

Question: Which takes precedence—coverage under Medicare or coverage under the Medical Assistance program of the Illinois Department of Public Aid? Or are costs split between the two?

Answer: Medicare takes precedence over Medical Assistance. When a physician performs a medical procedure for a public aid recipient having Medicare benefits, he bills the carrier on the Social Security Administration's billing form SSA 1490, with a duplicate copy to the Medical Administration Division, Illinois Department of Public Aid (IDPA) in Springfield.

The carrier pays Medicare's coverages direct to the physician, making a full explanation of benefits, with a duplicate copy to IDPA. At this point, IDPA compares the charges as billed by the physician with the benefits actually paid by the carrier to determine IDPA's financial responsibility, if any. If the physician's charges exceed the Medicare benefits received, some or all of the deficit **may** be made up by IDPA—if the services are allowable—at IDPA's standards of usual, customary and reasonable rates.

Thus, there is no cost sharing, *per se*. Rather, Medicare is a first resort cost source and Medical Assistance is a second.

Question: What is meant by Part A and Part B Medicare coverage?

Answer: It is not the purpose of this article to describe Parts A and B of Medicare as these subjects are detailed and kept current in two Social Security Administration publications, one titled, "Your Medi-

care Handbook," and the other, "Medicare—a Reference Guide for Physicians."

Part B—Medical Insurance—is sometimes referred to as SMIB which is short for Supplementary Medical Insurance Benefits. It is a source to help pay charges by physicians, outpatient hospital departments, home health agencies, independent laboratories, and to certain other providers of service. Discussion in this article is confined to those charges for services provided by a physician.

Question: Do many public aid recipients also have Medicare benefits?

Answer: The number is substantial as it includes nearly all persons age 65 or over.

Question: How may the doctor determine that the recipient patient is eligible for Medicare?

Answer: There are several indicators. The most obvious and soundest is that the patient possesses a Medicare Card issued by SSA. The green case identification card issued by IDPA to a recipient does not show specifically whether a recipient is covered by Medicare. However, all public aid recipients, age 65 or over, who receive a financial grant are covered by Medicare. They can be identified by the first two digits of the case identification number. If the digits are 01, 02, 03, 04, or 06, the recipient is a grant case and is covered by Medicare. Digits other than the foregoing, may or may not have Medicare coverage.

Being age 65 or over in itself does not assure SMIB coverage—it has to be applied

for and the insurance paid.

Question: Are many errors made in physicians' bills when the recipient patient is also covered by Medicare?

Answer: The error rate is quite high and ranks as a major factor in the reject of bills by the computer. For instance, the first machine schedule of physicians' bills in January, 1969, totaled 28,142, of which 3,919 bills were rejected for errors or imprecisions of all types. That is an overall reject rate of slightly less than 14 percent. Of the 3,919 rejected bills, 562 or 14.3 percent related to cases in which the recipient was also covered by Medicare. Considering that these figures pertain only to the first of five scheduled runs in January, the cumulative monthly total of errors is seen to be very substantial.

Question: What are some of the more common billing errors?

Answer: A very common error is failure to enter a recipient's case identification number in answer to question five on the Form SSA 1490. Without this number, the carrier will not send a copy of the Medicare payment and explanation of benefits to IDPA. Without this copy, IDPA cannot determine its responsibility for payment. This type of error causes follow-up action by the physician and a delay in payment.

Entering the case identification number incorrectly is another cause of computer reject. Sometimes the patient is not determined to be covered by Medicare and the physician bills IDPA first, using Form MS 132, instead of billing the carrier first, using Form SSA 1490. IDPA cannot initiate payment as Medicare is the source of first resort. The bill then must go back to the physician.

The same concern for precision governs the filling out of the Form SSA 1490 as for the Form MS 132 described in preceding installments of this series. The American Medical Association's booklet, "Current Procedural Terminology," is the source for coding and explaining the medical procedures performed.

Question: The billing-payment system, in this instance, calls for three different parties to perform three separate, but integral actions. Does this add to the possibility of error?

Answer: There is no doubt that each party must perform his portion of the sys-

tem accurately and promptly or there can be error, frustration, or delay. None of the three actions is particularly difficult—but each must be performed precisely and in the proper sequence.

There is some tendency to "jog" IDPA when its part of the action seems overdue. But it should be remembered that a Form SSA 1490 bill requires more actions and passes through more hands than does a regular physician's bill processed on a Form MS 132. When the IDPA receives the duplicate copy of the original Form SSA 1490 sent to the carrier, it is placed in suspense awaiting the arrival of the carrier's copy of payment and explanation of benefits. Only then can IDPA's payment responsibility be determined and action taken.

Question: In Illinois, how many carriers make Medicare payments for physicians' fees?

Answer: Two. A physician practicing in either Cook, DuPage, Kane, Lake, or Will counties should send his Form SSA 1490 to Blue Shield. A physician practicing in one of the remaining counties sends his bills to Continental Casualty.

HAVE YOU A QUESTION?

Physicians' questions concerning IDPA methods, procedures and policies are solicited and will be answered in these articles or by direct communication. The Department is desirous of eliminating misunderstandings and to work cooperatively with Illinois physicians. Send questions to:

IDPA Editor
Illinois State Medical Society
360 N. Michigan Avenue
Chicago, Illinois 60601

Question: How is the assignment of Medicare benefits handled?

Answer: IDPA requires all recipients eligible for Medicare to sign over their benefits to the providers of medical services. These blanket assignments are maintained by the appropriate county department of public aid. The physician (or other provider of medical services) usually accepts this assignment of benefit, but he need not do so. Administration of bills is faster and payment surer if he accepts the assignment of benefits. If he doesn't,

(Continued on page 340)



By LEON LOVE, M.D.

*Director, Department of Diagnostic Radiology, Cook County Hospital,
and Clinical Professor of Radiology, Chicago Medical School*

Patient is a 23 year old white female who entered the Cook County Hospital because of an abnormality noted on a mass survey film of the chest. The patient was asymptomatic. Fluoroscopically the left hemidiaphragm moved minimally and appeared to be moving in a direction opposite to that of the right hemidiaphragm.

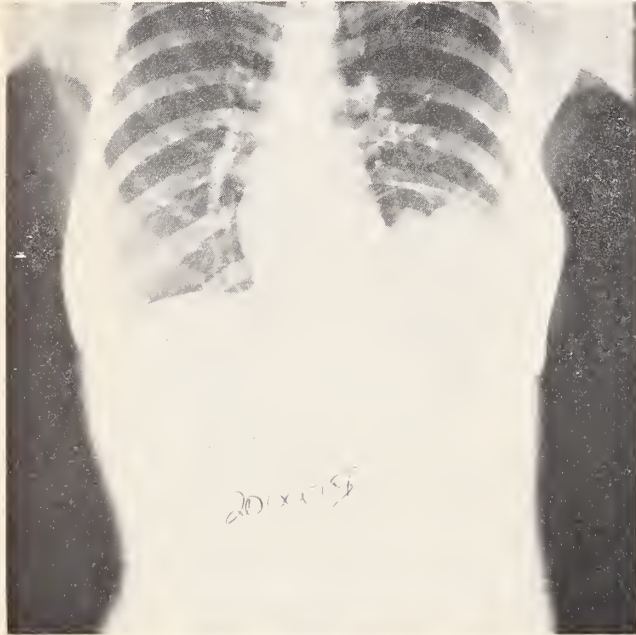


Fig. 1.



Fig. 2.

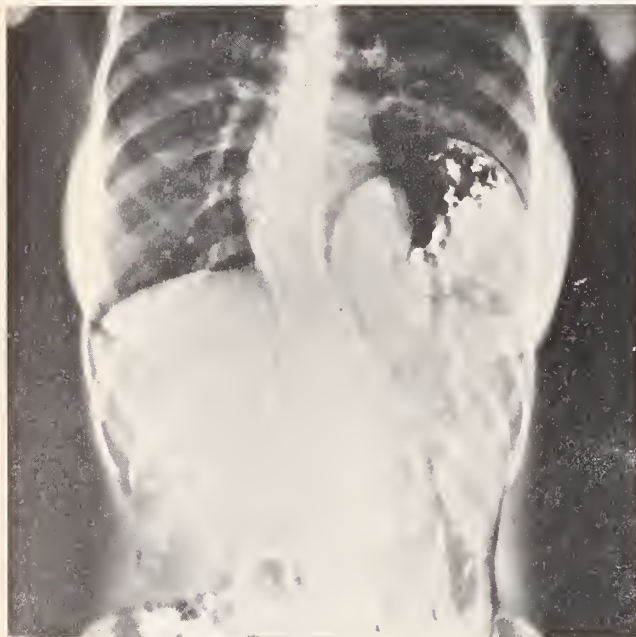


Fig. 3.

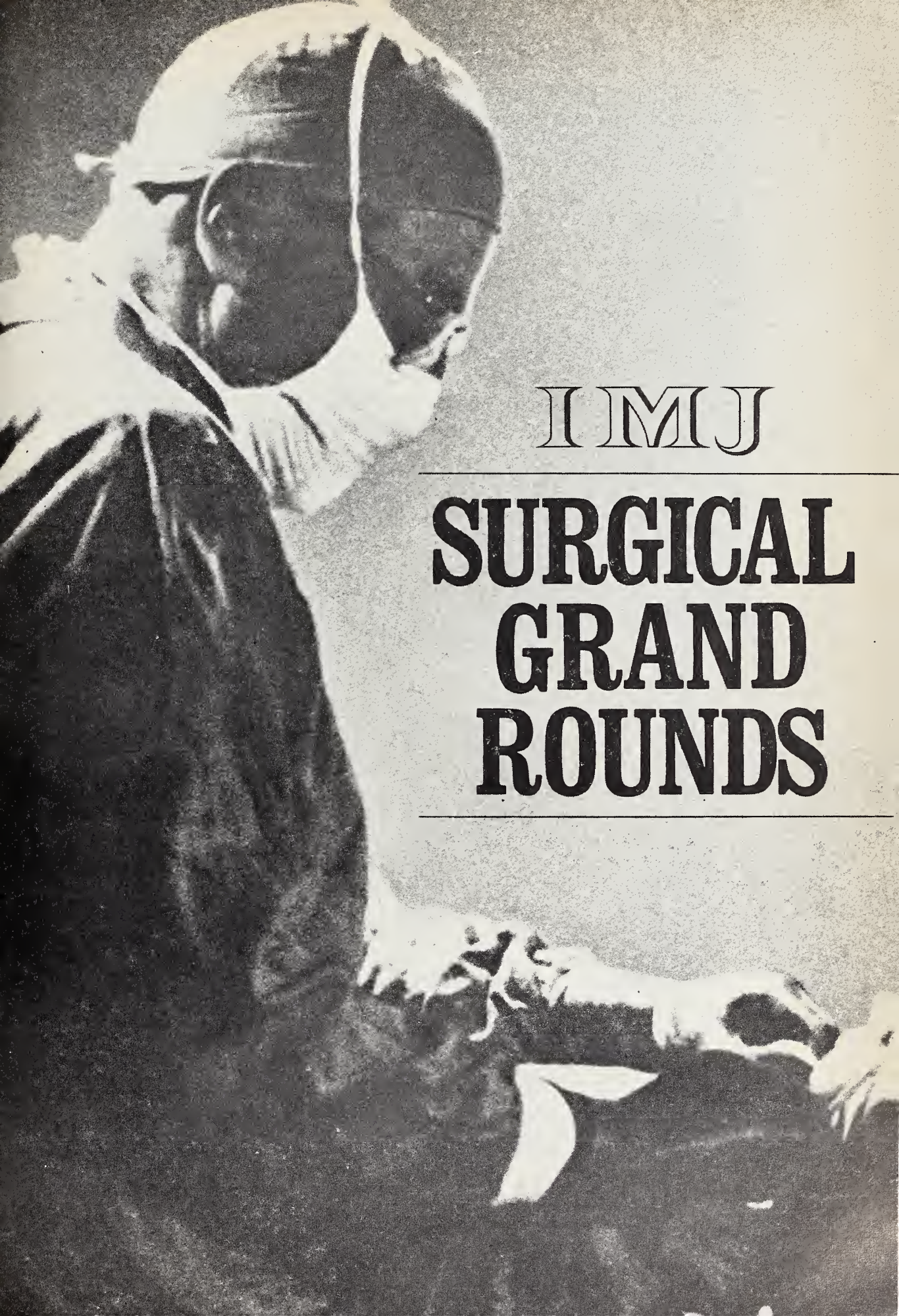
What's your diagnosis?

- 1) Traumatic hernia of the left hemidiaphragm.
- 2) Eventration.
- 3) Sequestration of lung.



Fig. 4.

(Answer on page 348)



IMJ

**SURGICAL
GRAND
ROUNDS**

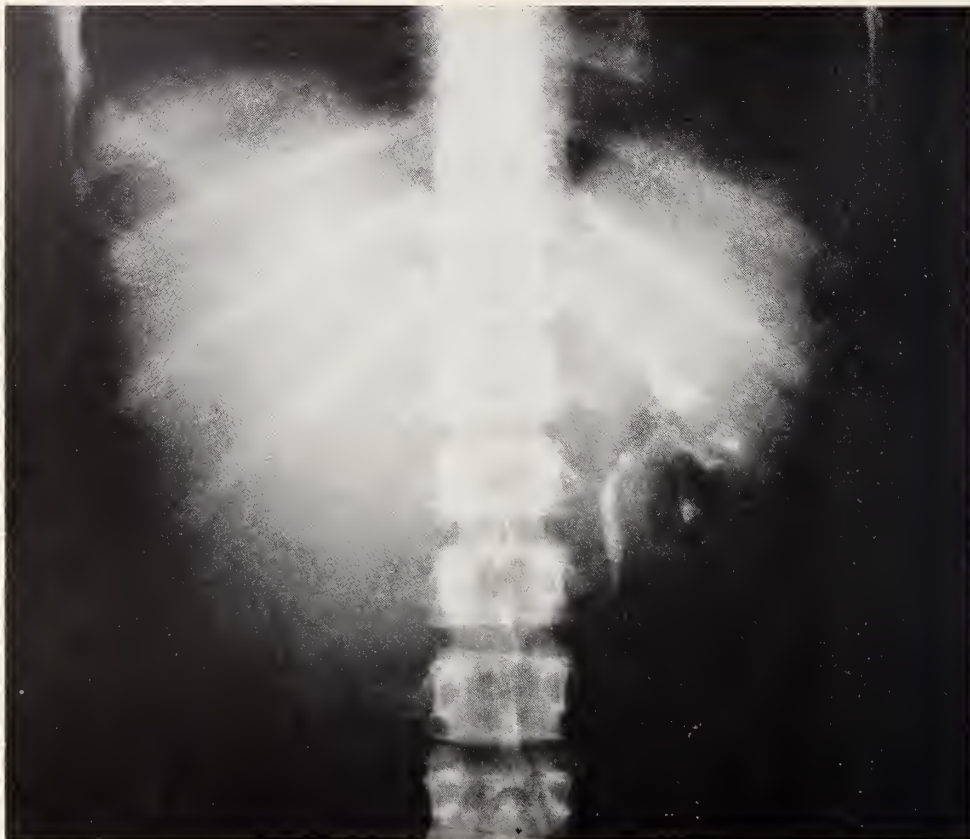


Fig. 1. Pyelogram demonstrating absent right kidney and large homogeneous mass density filling the right abdomen.

Non-Parasitic Cyst Of The Liver

Case Presentation

Surgical Grand Rounds are held weekly on Saturday at 8:00 A.M.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on May 18, 1968.

Dr. George Geier: A 24 year old Negro girl came to the hospital April 24, 1968 complaining of mild aching pain in the right flank and in the right upper quadrant. This had been troublesome for about seven months. The pain was unrelated to her activity and she did not complain of other gastrointestinal symptoms. In August of 1965 she had a nephrectomy for adenocarcinoma of the right kidney. A cesarean section was performed eight months later, at which time there was no evidence of persistent tumor.

When she was examined there was an obvious mass in the right flank and right upper quadrant. It seemed cystic and had rounded edges, extending to the right iliac crest and to the midline. The mass was not tender, and there were no other masses. Bowel sounds were normal. Her blood count was unremarkable. Urinalysis, bilirubin, and alkaline phosphatase were normal. X-rays were obtained.

Dr. Hirsch Handmaker: The intravenous pyelogram demonstrates the absence of a right renal shadow and collecting system with the left side appearing normal (Fig. 1). There is a large homogeneous mass density filling the right half of the abdomen. On the upper gastrointestinal examination the mass is seen to extend across the midline, deviating the duodenal bulb and loop downward and to the left (Fig. 2). On

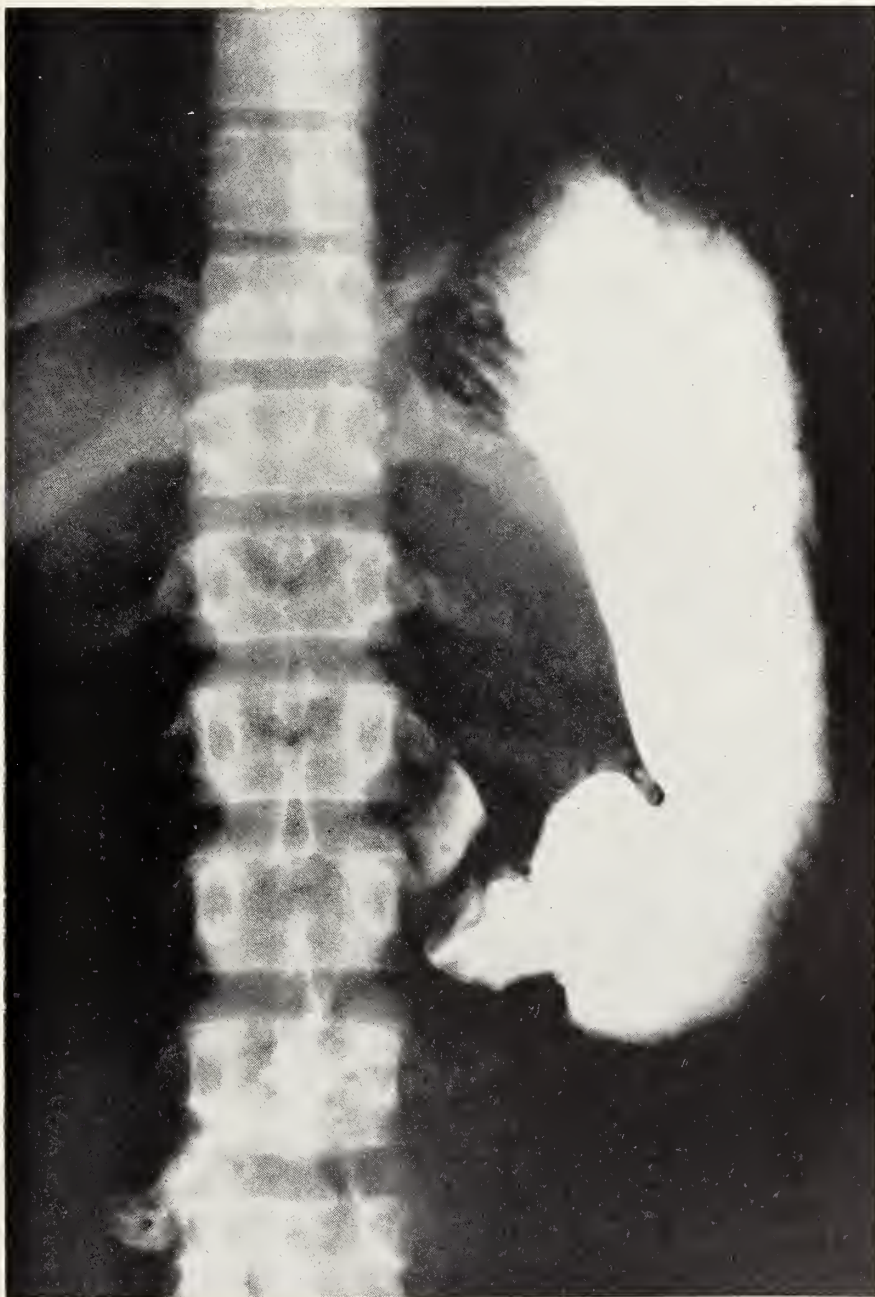


Fig. 2. Stomach and duodenal film showing marked deviation of duodenal bulb and loop away from a large right upper quadrant mass.



Fig. 3. Anterior liver scan showing massive filling defect in the right lower lobe area, and additional defect beneath diaphragm in right upper lobe region.

barium enema examination the hepatic flexure of the colon is likewise depressed by the mass. These findings all point to a large hepatic mass or enlargement.

The anterior Technetium sulfur colloid liver scan reveals large areas of diminished uptake, one in the lower portion of the right lobe, this being massive in size, and a lesser area in the infradiaphragmatic portion of the right upper lobe (Fig. 3). It is impossible to differentiate the possible etiologies for these defects. Multiple metastases, abscesses or cysts could all appear this way. The role of the liver scan in patients with polycystic liver disease and cystic disease in general has recently been emphasized by Rosenthal and others. Correlation with the clinical status and other radiological procedures may help in the differentiation.

Dr. Geier: Operation was performed May 6th. A large cyst was found in the right lobe of the liver, which was unroofed and the edges oversewn (Fig. 4). Drains were inserted into the area.

The Patient Enters:

Dr. Marion Anderson: What was your chief complaint when you came to the hospital?

Patient: I had a pain in my back. It would come and go.

Dr. Anderson: What sort of symptoms did you have when you had the original operation for your kidney? Was that the same type of pain then too?

Patient: It was the same thing.

Patient Leaves:

Dr. Anderson: Because of the patient's past history we were convinced that this mass was due to a recurrence of the renal neoplasm. Dr. Grayhack, our urological consultant, was just as convinced that this

was not a recurrence of the renal neoplasm. The lesion was cystic. When the liver scan demonstrated a filling defect he was further influenced against a renal neoplasm since spread to the liver is rare with this tumor. Thus, Dr. Grayhack must receive credit, painful as it may be, for directing us down the right avenue. Other cystic lesions were also considered preoperatively, including adrenal cysts, which usually result from hemorrhage associated with trauma.

At the time of operation the diagnosis was immediately apparent. The cyst had a characteristic blue-domed appearance with normal hepatic parenchyma along the periphery. Approximately 1,500 cc. of a dark-brown, turbid fluid was aspirated from the cyst. There was a second smaller cyst along the inferior edge of the main cavity which measured 6 cm. in diameter. There was some concern, because of the appearance of the liver scan, that there might be another cyst deep in the substance of the liver. However, we were not able to demonstrate another area of cystic change. The common wall between the two cysts was excised. We felt that external drainage of the cyst would very likely result in recurrence. Therefore, the external wall was excised with a rim of liver tissue, and the divided edge was oversewn with a running-lock stitch of 3-0 chromic catgut. There were many large biliary ducts in the wall of the cyst which drained bile as we excised the free wall. Each of these ducts was suture-ligated with fine black silk. Because of the number of these ducts, as well as their size, we also elected to decompress the extrahepatic biliary duct system with a cholecystostomy during the healing phase. In addition several large Penrose drains were positioned in and around the opened cyst cavity to prevent collection of fluid in the subhepatic area. The gallbladder, incidentally, was immediately adjacent to the wall of the cyst on its medial aspect.

We have seen several of these hepatic cysts. Figure 2 was a small cyst which was an incidental finding in a patient who underwent anterior resection for carcinoma of the upper rectum. We felt that it would be a mistake to disturb this cyst at that time, and she has had no trouble over the last five years. A third case, which was

cared for at Passavant in 1957, contained about four liters and involved the entire left lobe of the liver as well as the superior surface of the right lobe. Dr. Thomas Shields and I reviewed the subject and reported this case in 1960¹. At that time there were slightly over 200 solitary cysts reported in the literature. Bristow reported the first example of a solitary cyst in 1856. The largest cyst recorded in the literature was 17 liters.

Polycystic disease is most common in children. Solitary non-parasitic cysts are more frequently seen in adults, and for some reason more often in females. These patients may reach the age of 40 to 50 before compression symptoms are pronounced. The cause of hepatic cystic disease is not entirely clear, although they are probably due to a congenital abnormality of the intrahepatic ductal system. Whether this represents a hamartoma, in which there is a localized collection of aberrant biliary ducts, or whether it should be classified as diffuse "biliary angioma" formation is unknown. Although hepatic cysts are uncommon, they certainly must be kept in mind when one suspects a large cystic lesion in the upper abdomen.

Dr. John Beal: Dr. Anderson, what was the preoperative diagnosis?

Dr. Anderson: As I mentioned before I thought this was a recurrent renal tumor. I should have not leaned quite so heavily for this because less than two years ago the patient was delivered by cesarean section and the upper abdomen was considered normal at that time.

Dr. Michael Govostis: In 1960 we saw a patient who presented with a large mass in the right upper quadrant of the abdomen. This photograph of the x-ray of the abdomen shows two apparent densities in the region of the right liver, a large hydrops of the gallbladder and the other a cystic mass in the liver. This photograph shows the resected hemangioma from her liver. It was 8 or 9 cm. (decompressed) and the cut section showed it to be hamartoma.

About five months ago we had a man in the hospital in his mid 70's. He had been running a fever for two months. A liver scan showed a large defect in the liver. Flocculation and hemagglutination tests for *ecchinococcus* were negative. One morning while in the hospital he presented with



Fig. 4. Appearance of hepatic cyst in right lobe of liver at the time of operation.

signs and symptoms of an acute surgical abdomen. We operated upon him and he had a spontaneous rupture of a solitary cyst of the liver. It was on the anterior border of the right lobe of the liver and there was chocolatey-brown material throughout the abdominal cavity. There was no active bleeding. We drained the cyst and he recovered. It was a simple unilocular cyst.

Dr. Stuart Poticha: In the differential diagnosis of a mass in the liver the question of needle biopsy may arise. At another hospital about four years ago there was a patient with a large mass in the liver. A needle biopsy was performed. The mass proved to be a hemangioma of the liver and disastrous bleeding occurred. Needle biopsy is inadvisable in circumstances such as this patient presents. ◀

Reference

1. Anderson, M.C. and Shields, T. W.: "Large solitary non-parasitic cyst of liver." *Arch. Surg.* 80:296, 1960.



Membership Forum

Dear Illinois Physician:

The Medical Genetics Section of the Department of Preventive Medicine and Public Health at Creighton University School of Medicine, Omaha, Neb., is interested in the study of patients showing an increased incidence of any histological variety of cancer in their families. Of particular interest to us is the cancer family syndrome, characterized by: 1) increased frequency of adenocarcinoma of all sites, particularly of the colon and endometrium, 2) early age at onset of cancer, 3) increased occurrences of multiple primary malignant neoplasms, and 4) autosomal dominant inheritance.

We are currently updating two large cancer families having the above characteristics who live primarily in the Midwest, in middle and northwestern Missouri, Iowa, Nebraska, Colorado, Michigan, Indiana, and Illinois. The initial phases of the investigations of the families have been published (Lynch, H. T., *et al*: "Hereditary Factors in Cancer: Study of Two Large Midwestern Kindreds," *Arch. Intern. Med.* 117:206-212, 1966).

Physicians with patients known to have a familial cancer background may write to Henry T. Lynch, M.D., Associate Professor and Chairman, Department of Preventive Medicine and Public Health, Creighton University School of Medicine, 657 North 27th Street, Omaha, Neb. 68131.

We invite your cooperation in our studies which will include a genealogical and medical investigation of the entire kindred in each case. All information obtained will be shared with family physicians in order to facilitate cancer control.

Henry T. Lynch, M.D.
Dept. of Preventive Medicine
Creighton University

Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.

Dear Dr. Van Dellen:

I write in an effort to inform my colleagues of an important fact-finding mission I am currently engaged in, and to alert them to expect to hear from me personally.

I have taken a year's leave of absence from my private practice in New Jersey to serve with a fact-finding agency of government known as the National Commission on Product Safety. This Commission was established by Congress to develop effective means to protect Americans from unreasonable hazards related to many products commonly used in and around the home today.

Every physician in the country—as a consumer—will benefit from the work of this Commission. So will his family, his patients, and all Americans.

I plan to contact "front line" physicians—those dedicated and competent individuals who get the calls and see the victims of accident inquiries—in a nationwide survey of product-related accidents. A questionnaire will be mailed to the medical profession's "front liners" during the month of March. The questionnaire will seek to elicit information on all product-related injuries treated during the first two weeks in April.

In the last ten years has been seen a rising tide of interest in and legislation for prolonging American lives, ranging from better automobile design to warnings against smoking. The National Commission on Product Safety's work is directed toward household product safety.

I am counting on the wholehearted cooperation of the medical profession for the priceless information that only physicians can make available to this Commission.

Sincerely,
Samuel C. Southard, M.D., FAAP
Director, Task Force I
National Commission on Product Safety

The recent merger of Epilepsy Association of America and The Epilepsy Foundation into Epilepsy Foundation of America opens new horizons in the voluntary movement against epilepsy. For all the facts, write Epilepsy Foundation of America, Washington, D.C., 20005.

Medical-Legal Problems of Illinois Physicians

Medical Practice Act

BY FRANK M. PFEIFER, LEGAL COUNSEL, ISMS/SPRINGFIELD

The Medical Practice Act of Illinois, which is found under Paragraphs 1 through 16x of Chapter 91 Illinois Revised Statutes, 1967, (Sections 1 through 39), sets out most of the statutory law having to do with the practice of medicine. This Act basically covers three different categories, namely:

1. Persons authorized to practice medicine in all of its branches.
2. Persons authorized to practice a system or method of treating human ailments without the use of drugs or medicine and without operative surgery.
3. Persons authorized to practice midwifery.

No one shall practice in any of the categories listed above unless he shall have a valid existing license issued by the Illinois Department of Registration and Education (hereinafter referred to as "Department").

Each applicant for a license shall submit evidence, under oath, satisfactory to the Department that:

- a. He is 21 years of age or over;
- b. He is of good moral character;
- c. He has the preliminary and professional education required by this Act to practice under the category he chooses;
- d. He is a citizen of the United States or had made a declaration of intention to become a citizen or has filed a petition for naturalization. Any non-citizen licensed under this Act shall be obligated to perfect his United States citizenship if his license is to be renewed.

The application shall specifically designate the name and location of the professional school from which he is a graduate and the system or methods of treatment under which he seeks to practice.

The minimum educational requirements necessary for the taking of licensure examinations

1. *For The Practice of Medicine in All of its Branches:*

The IMJ, in attempting to bring to the physicians of Illinois information that is of importance and concern to them, will carry medical-legal articles written by the legal counsel of the Illinois State Medical Society. These articles will be based upon actual experiences, questions and problems as they arise from time to time throughout the State. Answers to individual queries and specific problems cannot be furnished in these columns.

Applicant shall be a graduate of a medical college which required as a prerequisite to admission a two-year course of instruction in a college of liberal arts or its equivalent, and a course of instruction in a medical college in the treatment of human ailments, which course shall have had a duration of at least 132 weeks and shall have been completed within a period of not less than 35 months, and in addition thereto a course of clinical training of not less than 12 months in a hospital with such colleges of liberal arts, medical college and hospital having been reputable and in good standing in the judgment of the Department.

2. *For The Practice of Treating Human Ailments Without Drugs or Medicine and Without Operative Surgery:*

Applicant shall be a graduate of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application, and such school, college or institution at the time of his graduation required as a prerequisite to admission a four-year course of instruction in a high school and a course of instruction in the treatment of human

ailments for which he seeks a license of not less than 132 weeks in duration and which shall have been completed within a period of not less than 35 months and with such schools, college or institution having been reputable and in good standing in the judgment of the Department. Any applicant who matriculates in a chiropractic college after September 1, 1969 shall be required as a prerequisite for an examination to complete a two-year course of instruction in a liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course having been of not less than 132 weeks in duration and being completed within a period of 35 months with such college of liberal arts and chiropractic having been reputable and in good standing within the judgment of the Department.

3. For The Practice of Midwifery:

Applicant for the practice of midwifery shall be a graduate of a college of midwifery which requires as a prerequisite to admission thereto one-year's course of instruction in a high school or its equivalent and further at least one-year's course in such college of midwifery. The time actually spent in such college to have been not less than 12 months with such high school and college having been reputable and in good standing in the judgment of the Department.

In 1965 the Legislature amended the Act to provide that after August 2, 1965 no additional licenses in midwifery could be issued so that this category will terminate as soon as existing practitioners of midwifery are terminated by failure to renew or death.

Every applicant who successfully passes an examination shall be entitled to an appropriate license. Currently there are only two types of licenses issued:

(a) The license to practice medicine in all of its branches which is the unqualified license and covers the entire field of medicine.

(b) The license to treat human ailments without the use of drugs or medicine and without operative surgery.

Persons in this latter category are restricted to the practice or system or method which was specifically designated on the application and for which the examination

has been passed. This category is made up primarily of chiropractors but does include other so-called methods of practice but in no case can drugs, medicine or operative surgery be used. Osteopaths in Illinois now take the same examination as those seeking to practice medicine in all of its branches and if successful are entitled to and receive an unlimited license.

Examination of Applicants

Examination of applicants who seek to practice medicine in all of its branches shall cover the subjects which are generally required of candidates for the degree of Doctor of Medicine by reputable medical colleges in the United States and shall be such as in the judgment of the Department will determine the qualifications of an applicant to practice medicine in all of its branches.

Examination of applicants who seek to practice a system of treating human ailments without the use of drugs or medicine and without operative surgery shall be the same as required of applicants who seek to practice medicine in all of its branches but excluding therefrom materia medica, therapeutics, surgery, obstetrics and theory and practice. Such examinations shall be such, as in the judgment of the Department, will determine the qualifications of the applicant to practice the particular system or method of treating human ailments without the use of drugs or medicine and without operative surgery, which specialty he specifically designates in his application as the one which he would undertake to practice. If the applicant is a graduate of a professional school in which obstetrics was taught to him, he may also be examined in this subject if in the judgment of the Department such subject was taught to him as well as it would have been taught in a medical college in good standing with the Department. If the Department recognizes the school and the applicant passes said examination, he may thereafter practice obstetrics.

Examinations conducted by the Department under this Act shall be under reasonable rules and regulations prescribed by the Department. Examinations shall be held at least four times each year and may be wholly written or both written and oral.

Temporary Certification

Persons holding the degree of Doctor of Medicine and those holding the degree of Osteopathy who are licensed to practice medicine in all of its branches in the state where they reside but who are not residents of the state of Illinois may obtain a temporary Certificate of Registration if they desire to pursue programs of graduate or specialty training in Illinois. In order to receive such a temporary Certificate, applicant must furnish satisfactory proof to the Department:

(a) That he is at least 21 years of age and of good moral character;

(b) That he has been accepted for specialty or residency training by a hospital in the state of Illinois with a statement of the beginning and ending dates;

(c) That he is not a resident of the state of Illinois and does not intend to remain in Illinois for the purpose of practicing medicine after the expiration of his temporary Certificate of Registration;

(d) That he is a graduate of a medical school or college in good standing with the Department;

(e) That he is licensed to practice medicine in all of its branches in the jurisdiction in which he resides or has passed an examination which in the judgment of the Department is the equivalent of the requirement of Illinois to practice medicine in all of its branches.

Temporary Certificates shall be valid only for the period of time designated therein but may be extended or renewed in the discretion of the Department. The holder of a valid temporary Certificate shall be entitled thereby to perform such acts as may be prescribed by and incidental to his program of residency training but shall not entitle him to otherwise engage in the practice of medicine in Illinois. Such temporary Certificate may be revoked by the Department upon proof that the holder thereof has engaged in the practice of medicine in Illinois outside the subject matter of his residency or special training or if he fails to provide the Department with necessary information requested of him. If an individual holding a temporary Certificate should in good faith change his mind about remaining in Illinois after the completion of his residency training, he shall be eligible for a license by ex-

amination.

Anyone licensed to practice any system of treating human ailments without the use of drugs or medicine and without operative surgery may take the examination to practice medicine in all of its branches if satisfactory proof is made to the Department that he has completed all courses of study in approved institutions which would have qualified him to take this examination in the first instance.

The Department in its discretion may issue a license without examination in any of the categories provided for under the Illinois Act under the following conditions:

(a) The applicant is a citizen of the United States or has made a declaration of intention or has filed for naturalization or if not eligible for naturalization has filed with the Department an oath that while in the United States he will remain loyal and will not affiliate with any organization which advocates the overthrow of the government of the United States by force or violence. This loyalty oath is good for five years only and may not be renewed.

(b) The applicant is of good moral character.

(c) That if the applicant seeks to practice medicine in all of its branches he must be a graduate of a medical school in good standing in the judgment of the Department at the date of his graduation, and the requirements in the particular state, territory, country or province in which he is licensed are deemed by the Department to be substantially equivalent to the requirements in Illinois.

(d) That if the applicant seeks to treat human ailments without the use of drugs or medicine and without operative surgery he must be a graduate of a professional school which taught the treatment of human ailments which he specifically designated in his application, which school was in good standing in the judgment of the Department at the date of his graduation, and that the requirements for his license in the system or method selected by him are deemed by the Department to have been substantially equivalent to the requirements in Illinois.

(e) That the state, territory, country or province in which applicant was licensed shall be accorded a like privilege to persons so licensed in Illinois.

(f) The Department may in its discretion issue a license without examination to any graduate of a professional school in good standing in the judgment of the Department who has passed an examination for admission to the United States Public Health Service.

The Department is empowered to consider and evaluate each applicant for license without examination and may consider the quality of clinical training which the applicant has had. No such license without examination shall be issued to any person who has previously taken and failed the Illinois examination.

The Department may in its discretion issue, without examination, a permit to practice medicine in all of its branches in Illinois hospitals to individuals who meet the following qualifications:

- (a) Over 21 years of age.
- (b) Good moral character.
- (c) Training which the Department considers adequate.
- (d) Has served a one-year internship in a hospital approved by the Department.
- (e) Has been appointed in a hospital maintained by the State of Illinois.

Anyone holding such a permit on July 1, 1965 may have it renewed, with each renewal being for a period of two years. Anyone receiving a permit after July 1, 1966 may have it renewed for two-year terms with the limit being three renewals. At the time of any renewal, applicant must provide the Department with proof that he is applying himself to a course of study in order to qualify to take the regular examination in order to obtain an unlimited license to practice medicine in all of its branches.

The Department at least once a year shall publish a list of the names and addresses of all persons licensed under the Act and also a list of those persons whose licenses have been suspended or revoked since the last report. A copy of this list must be mailed to the County Clerk of each county and shall be held by the said Clerks as a public record which of course means that the list is available for inspection by anyone desiring to look at it. These lists shall also be mailed by the Department to any person in the state of Illinois requesting them.

Revocation

The Department may revoke or suspend the license, certificate or state hospital permit or may refuse to grant a license, certificate or state hospital permit under the Act upon any of the following grounds:

(a) Convicted of procuring or attempting or aiding to procure an abortion, except when such abortion shall have been necessary for the preservation of the woman's life and shall have been performed in a licensed medical facility.

(b) Conviction of a felony in any state or federal court.

(c) Gross malpractice resulting in the permanent injury or death of a patient.

(d) Engaging in a dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

(e) Obtaining a fee or anything of value either directly or indirectly as personal compensation or as compensation for another upon the fraudulent representation that a manifestly incurable condition of sickness, disease or injury may be permanently cured.

(f) Habitual intemperance in the use of alcohol to such an extent as to incapacitate the individual for the performance of professional medical duties.

(g) The holding out of one's self to treat human ailments under any name not his own or the impersonation of a physician.

(h) The use of fraud, deception or any unlawful means in applying for or securing a license, certificate or state hospital permit under the Act or in passing any examination by willful and fraudulent violation of the rules and regulations of the Department.

(i) Holding one's self out to treat human ailments by making false statements or by specifically designating any disease or group of diseases and making false claims as to one's skill or the value of one's medical treatment or remedy therefore.

(j) Professional connection or association with or lending one's name to another for the illegal practice by another of the treatment of human ailments provided for under the Act.

(k) Revocation or suspension of a license in another state.

(l) A violation of any provisions of

the Act or of the rules and regulations promulgated by the Department for the administration of the Act.

(m) Advertising or soliciting by one's self or through another in any manner except that any person licensed under this Act may, provided bold face type is not used:

(1) List his name, title, office hours, address, telephone number and any specialty in professional and telephone directories.

(2) Announce by means of a professional card not larger than $3\frac{1}{2} \times 2$ inches his name, title, degree, office location, office hours, phone number, residence address and telephone, and any specialty.

(3) List his name, title, address, telephone number and any specialty in public print limited to the number of lines necessary to state the information and may announce his change of place of business, absence from and return to business in the same manner.

(4) Issue appointment cards to his patients, when the information thereon is limited to the time and place of appointment and the information permitted on business cards.

The Department may upon its own motion and shall on verified complaint in writing by any citizen setting forth facts which, if true, would constitute grounds for suspension or revocation of license, certificate or permit, investigate the actions of any person who holds or claims that he holds a license, certificate or permit under this Act. The Department must, before suspension or revocation of any license, certificate or permit give the accused at least 30 days written notice of the charges directed against him and the date and place set for hearing and notify him that he has 20 days in which to file his answer. In the event no answer is filed, default may be taken and the license, certificate or permit suspended or revoked.

The examining committee provided for in this Act shall hear charges and complaints and both the accused and complainant shall be offered ample opportunity to present in person or by counsel such statements, testimony, evidence or argument as may be pertinent to the issue.

The Department has the power to

subpoena and to bring before it any person in this state for the purpose of taking testimony either orally or by deposition or both. The examining committee and certain offices of the Department have the power to administer oaths.

Any circuit court upon application of the accused or complainant or Department shall order the attendance of witnesses and the production of relevant books and papers before the department at any hearing for the recall, suspension, revocation or refusal to issue a license, certificate or permit. Power is given to the court to compel obedience to the order by contempt proceedings.

The Department at its own expense shall maintain a stenographic record of the entire proceedings in all cases wherein suspension or revocation of a license, certificate or permit is in issue. A transcript of the proceedings before the Department is available to any interested party upon the payment of the cost thereof. The examining committee shall make a written report of its findings and recommendations, copy of which shall be served upon the accused and within 20 days after such service, the accused may ask for a rehearing, which motion must be in writing and specify the particular grounds therefor.

Rehearings shall be at the discretion of the Director of the Department. If no hearing is sought, the Director shall take the action recommended by the committee. In the event rehearing is sought and granted, the committee shall again make its written report after the conclusion of the rehearing and this report shall be followed by the Director. Upon the suspension or revocation of a license, certificate or permit, the holder shall surrender said license, certificate or permit to the Department or upon his failure to do so, the Department may seize said documents.

At any time after the suspension or revocation of a license, certificate or permit, the Department may restore same to the accused without examination upon the written recommendation of the examining committee.

All final decisions of the Department are subject to Judicial review under the provisions of the Administrative Review Act with said proceedings to commence in the circuit court of the county in which the accused resides.

Medical Examining Board

None of the functions, powers and duties set forth in this Act shall be exercised by the Department, except upon the action and report in writing of the examining committee. The examining committee shall consist of 7 persons, 5 of whom shall be physicians licensed to practice medicine in all of its branches, one of whom shall be an osteopath and one a chiropractor, with one of the 5 physicians being a full time teacher of medicine at the University of Illinois College of Medicine. The present physician members of this committee are:

Chairman: Kenneth H. Schnepf, M.D.
727 South 2nd Street
Springfield, 62704

William Johnson, M.D.
Post Office Box 109
Galesburg, 61401

William G. McCarthy, M.D.
13826 Lincoln Avenue
Dolton, 60419

Warren D. Tuttle, M.D.
203 North Vine Street
Harrisburg, 62946

(*Ed note:* As of this writing one physician member vacancy exists on the Board.)

The Department shall promulgate reasonable minimum standards for the educational requirements of medical colleges and all other professional institutions coming within the purview of the Act and shall determine reputability and good standings of all such institutions. The Department shall also promulgate all necessary rules and regulations required for the administration of the Act.

The provisions of this Act shall not be construed nor shall the administration by the Department be in such manner as to discriminate against any system or method of treating human ailments or against any institution of learning coming within the provisions of the Act.

Any person holding a valid license to practice medicine in all of its branches or to treat human ailments without the use of drugs or medicines and without operative surgery who in good faith provides emergency care without fee at the scene of any motor vehicle accident or in case of nuclear attack shall not incur any liability for civil damages except if willful or wanton misconduct can be shown on the part of

such person.

An individual holding a valid license to practice medicine in all of its branches shall incur no liability for acts done while serving on a medical utilization committee except if willful or wanton misconduct is involved.

Violations of the Act

The following are violations of the Medical Practice Act and subjects the violator to criminal penalties:

(a) Engaging in any diagnosis or recommending any form of treatment or diagnosing or attempting to diagnose any ailments, or maintaining an office for the examination of persons afflicted or supposed to be afflicted with any ailment or attaching the title of doctor, physician, surgeon, M.D. or any other word or abbreviation indicating that he is engaged in the treatment of human ailments or attempting to practice under any of the provisions of the Act without holding a valid license therefor, issued by the State of Illinois;

(b) Engaging in the treatment of human ailments by the use of drugs or medicine or operative surgery while holding only a license to treat human ailments without the use of drugs, medicine or operative surgery;

(c) Engaging in the treatment of human ailments in any manner not constituting midwifery while holding only a limited license to practice midwifery;

(d) Anyone not licensed in Illinois to practice medicine in all of its branches but licensed to treat human ailments in some limited manner, not attaching to his name a word or words indicating the type of practice which he is authorized to pursue;

(e) Any person who obtains a financial profit of any kind either directly or indirectly either as compensation for himself or for anyone else upon the reputation that he can permanently cure a manifestingly incurable disease or injury;

(f) Any person who holds himself out to treat human ailments in any name other than his own or shall impersonate anyone licensed under this Act;

(g) Any person who holds himself out to treat human ailments by any system or method other than that for which he is licensed;

(h) Any person who uses fraud or de-

ception in applying for or securing a license under this Act or in passing any examination thereunder.

All of the offenses listed in "a" through "h" above shall upon conviction of the first offense be guilty of a misdemeanor and be punished by a fine of not less than \$200.00 nor more than \$1,000.00 or by confinement in the county jail for a period of not more than 1 year, or both such fine and imprisonment. Any person convicted of any of the offenses listed in "a" through "h" above and who subsequently is convicted of a second violation shall be deemed guilty of a felony and shall be punished by confinement in a penitentiary for from 1 to 5 years. In addition, whenever any person is convicted of a second or additional violations of this Act, he shall be considered a repeat offender and the Director of the Department of Registration and Education shall apply to the proper court for a permanent injunction restraining such person from further violation of the Act. The advantage of injunctive relief is that any violation of the injunction places the violator in contempt of Court which is punished by a jail sentence. Historically our Courts have been severe with injunction violators.

Any person who, in connection with any application or examination under the Act, files as his own any diploma, license or certificate of another shall be deemed guilty of a felony and upon conviction thereof shall be punished by a fine of not to exceed \$1,000.00, or imprisonment in the penitentiary for 1 to 14 years, or both such fine and imprisonment.

Any person who shall make a false oath or affirmation in connection with any application for a license or in submitting any complaint, evidence or testimony to the Department under the provisions of this

Act or any rule or regulation promulgated by the Department shall upon conviction be deemed guilty of a felony and shall be fined not to exceed \$1,000.00, or confined in the penitentiary for from 1 to 14 years, or both such fine and imprisonment.

The practice of any treatment of human ailments authorized by this Act by any person not at that time holding a valid and current license is hereby declared to constitute a public nuisance. The Director of the Department, the Attorney General of the State of Illinois, the States Attorney of any county in the state or any citizen may apply for an injunction in any court of competent jurisdiction to enjoin and prevent such person from engaging in such practice. Upon the filing of such a verified petition, if the judge is satisfied by the affidavit that such person has been engaged in the practice without a valid and current license, a temporary injunction may be issued without notice or bond prohibiting the defendant from such further practice. If upon hearing, it is established that the defendant has been so engaged, the Court shall permanently enjoin the defendant from such practice in the future. In all proceedings hereunder the Court in its discretion may apportion all of the costs in any equitable manner which would probably mean that all of the costs would be assessed against the defendant if a permanent injunction was issued. In the event of a violation of any injunction issued under this Act, the violator may be punished for contempt of Court. The injunction procedure shall be in addition to and over and above all other penalties and remedies provided in the Act.

While there are many other sections of our Statutes which affect the practice of medicine, the above is rather a detailed outline of the Medical Practice Act. ◀

Nursing Book Available

Volume II of "Nursing in Illinois" is now available. In contrast to Volume I which was an overview with conclusions and recommendations, Volume II contains the seven Committee Reports. These are: (1) Community Health Nursing; (2) Institutional Nursing; (3) Mental Health Nursing; (4) Nursing Education; (5) Nursing in Doctors' Offices; (6) Occupational Health Nursing;

and (7) Private Duty Nursing. Printed in the same format as Volume I, 136 pages, the price is \$2.00. If Volume I is ordered at the same time, both may be had for \$3.00. Reprints of individual committee reports may be obtained for 25¢ each.

Available from the Illinois Nurses' Association, 6 North Michigan Avenue, Chicago, Illinois 60602. Make checks payable to Illinois Nurses' Association.

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago, 60601.

MACON COUNTY: Argenta; population: 900; Oreana, 800. Towns without physicians since 1961. Nearest at Maroa and Cerro Gordo, 10 miles, and Decatur, 12 miles. Population of Decatur: 88,000. Community willing to build a building for a physician if desired. Agricultural area. Many residents commute to Decatur. Churches: Five Protestant. Grade and high schools. Millikin University, 10 miles. Nearest recreational facilities, including golf courses and swimming pools at Decatur. For further information contact:

Harold A. Miller
Superintendent of Schools
500 N. Main Street, Argenta,
Phone: 795-4822

MACON COUNTY: Macon; population: 1,300. Trade area, 5,000. Eastern Star Sanatorium with 75 women patients here. Nearest physician, 7 miles, in limited practice. Nearest hospital, Decatur, 10 miles. Office building available. Six months free rent. Financial assistance if desired. Agricultural and industrial area. Churches: Catholic and Protestant. Grade and high schools. Nearest recreational facilities at Decatur. Sears survey of community favorable. For further information contact: Macon Chamber of Commerce Council for Securing a Doctor, Mrs. Flossie McDaniel, Chairman, Mrs. Earl Johns, Secretary, Macon.

MACOUPIN COUNTY: Bunker Hill; population: 1,800. Trade area, 7,000. One

physician; urgent need for a second. Nearest hospital at Staunton, 15 miles; 17 miles to Carlinville. Alton-Wood River, 23 miles; population 70,000. Local drug store. Financial assistance can be arranged. Predominant nationality: German. Agricultural and industrial community. Churches: Catholic and Protestant. Grade and high schools. Nearby golf course. Local committee advises, "We are ready to start a fund raising campaign to provide low cost office space and equipment until the doctor can purchase it himself." For further information contact: Mrs. Norma Lee Ashcraft, Secretary, Bunker Hill Commercial Club, Bunker Hill.

MACOUPIN COUNTY: Chesterfield; population: 280. No physician since 1954. Nearest at Greenfield and Carlinville, 15 and 12 miles. Carlinville Hospital—58 beds. Alton, 28 miles; population 32,000. Financial assistance if desired. Agricultural area. Churches: United Church (Methodist and Congregational) and Episcopal. Grade school only; bus service to nearest high school at Carlinville. For further information contact: K. L. Woods, Cashier, Chesterfield State Bank, Chesterfield.

MACOUPIN COUNTY: Staunton; population: 4,500. Trade area, 15,000. Community Memorial Hospital located here; 65 beds; 40 miles from St. Louis, Mo. Two drugstores. Financial assistance if desired. Churches: nine Protestant and Catholic. Grade and high schools. Local country club. For further information contact: Staunton Memorial Hospital, Staunton, phone: 635-2200.

MADISON COUNTY: Highland; population: 5,000. Only 4 physicians, as compared to 10 in past. St. Joseph's Hospital, 175 beds; 2 million dollar modern well-equipped accredited hospital, receives patients from radius of 25 miles in all directions. Local physicians overworked and anxious to have others locate here. Forty minutes from downtown St. Louis. Excellent public and parochial schools. Churches: Protestant and Catholic. Country club with golf course. Several small industries. Excellent office locations. Three drug stores. For further information contact: Robert Holcombe, M.D., 1115 Washington St., Highland. Phones: 654-5161 & 654-5181.

The Historical Background of the Gridiron or Muscle-Splitting Incision for Appendectomy

BY E. LEE STROHL, M.D. AND
WILLIS G. DIFFENBAUGH, M.D./CHICAGO

It is now seventy-five years since the muscle-splitting incision was described by Dr. Charles McBurney and Dr. Lewis L. McArthur.

Surprisingly enough, two renowned surgeons, in separate sections of the United States, developed the muscle-splitting incision almost simultaneously—McBurney living in New York City, and McArthur in Chicago.

In the Spring of 1894, Dr. Lewis L. McArthur made application to the Chicago Medical Society to present a paper before the Society. The paper was titled: "Choice of Incisions of Abdominal Wall, Especially for Appendicitis,"¹ and it was scheduled for presentation at the June, 1894, meeting. Because of the length of the program, and the fact that McArthur was the last scheduled speaker, he agreed, on request, to postpone his presentation until an early Fall meeting of the Society.

At the November, 1894, meeting of the Chicago Medical Society, McArthur prefaced his paper by stating that since the application to the Society for an opportunity to present this subject, the Summer recess had occurred, and during that time Dr. Charles McBurney, of the Roosevelt Hospital, New York, in the July, 1894, issue of the *Annals of Surgery*, had advocated the same procedure.²

McBurney stated, in his publication, that he had used the muscle-splitting incision in four cases of recurrent appendicitis, the first having been done on a patient on December 18, 1893 or about six months prior to the publication of his technique.

McBurney qualified his recommendations for the use of the incision by the statement: "The operation does not appear to be suitable for cases accompanied by suppuration about the appendix, which require



Willis G. Diffenbaugh, M.D., (left) is Associate Clinical Professor of Surgery, University of Illinois and attending surgeon at Presbyterian-St. Luke's Hospital, Cook County Hospital and Skokie Valley Community Hospital. He is a graduate of Northwestern University Medical School. E. Lee Strohl, M.D., is Senior Attending Surgeon, Presbyterian-St. Luke's Hospital, and Consulting Surgeon, Cook County Hospital. Dr. Strohl is a member of the Chicago Board of Health, president, board of directors, Municipal Tuberculosis Sanitarium and president, Institute of Medicine of Chicago.



treatment by extensive packing with gauze, nor in cases non-suppurative which require, during the operation, a large intra-abdominal dissection. Sufficient time has not elapsed to justify me in presenting the final results as positively an improvement upon those obtained by older methods."

At the time of McArthur's reading of his paper, he stated that he had used the method in fifty-nine patients, the earliest of these being three years previous to the presentation. In contra-distinction to McBurney's description, McArthur recommended this incision for all types of appendiceal inflammation, suppuration, and abscess formation.

McArthur suggested the muscle-splitting incision in all types of disease of the appendix. His reasons were:

1) Less hemorrhage; 2) more distinct anatomy; 3) least possible danger of subsequent hernia; 4) if necessary to enlarge a wound, only one layer of muscles need be sacrificed; 5) less suturing; 6) patient need not be so carefully confined to one position; 7) less cellulitis.

The Minutes of the meeting of the Chicago Medical Society, which were signed by Junius Hoag, Secretary, are now in the records of the Chicago Historical Society, and reveal that McArthur's paper was discussed by Doctors John B. Murphy, Alex H. Ferguson, Arthur Dean Bevan, and Samuel Plummer.³

A significant item as to the historical interest is the statement of Dr. E. Wyllis Andrews that he had used McArthur's method for several years with great satisfaction.⁴

On reading McBurney's paper in the *Annals of Surgery*, McArthur immediately wrote McBurney on August 24, 1894, congratulating him on his contribution, and enclosed a copy of his own paper on the same subject, which, up to that time, had not been presented.

McBurney replied to McArthur in a cordial letter, dated October 10, 1894, and apologized for the delay in answering because of absence from home. In his letter he generously acknowledged the fact that McArthur should have priority of the use of this type of abdominal incision. Furthermore, several years later, at a dinner in Chicago honoring McBurney, he publicly acknowledged the same to his Chicago colleagues.

McBurney's letter was found in November of 1934 among the correspondence in the desk of McArthur at the time of his death. This letter is now in the archives of the John Crerar Medical Library of Chicago for historical interest.⁵

McBurney's letter to McArthur follows:

Highgate Springs, Vt.
October 10, 1894

My dear Doctor McArthur:

Your very kind and interesting letter of August 24th has followed me about in my wanderings. It deserved an answer long ago, but you will understand now why you have not received one. I am very grateful for your generous congratulations on the operation, for the earliest performance of which you however deserve the credit. I supposed that I had devised something entirely new, and your letter to me is the first intimation I have had that the operation had ever been done by anyone but me. But in these days when active clever workers are so numerous, the opportunities to devise anything entirely original are few and far between. I think the operation has hardly been appreciated even by those who have read the description—at least I have seen no comments upon it in the journals of my neighborhood. I think it is destined to supplant all other operations for the removal of the normal or of the chronically inflamed appendix. But who knows. You ask me what my practice is in cases in which an evident abscess exists. Unless some contraindication exists, I operate on them at once. If possible, I enter the abscess as near the outer edge of the abdomen as may be without opening up the general peritoneal cavity. The incision in the wall of the abscess is made as large as is consistent without opening the general cavity. The cavity is then merely mopped out very gently without irrigation and the appendix sought for. If readily found, it is removed. If a difficult dissection or a prolonged search would be required to remove the appendix, it is left to itself. The cavity is then moderately packed with iodoform gauze,—I almost never use a drainage tube. If it is necessary to open the general cavity in order to reach a deep abscess, the same method is applied, only taking great care not to in-

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Psychotherapy Applied to Comprehensive Medical Practice

By H. H. GARNER, M.D./CHICAGO

The Report of the Citizens Commission on Graduate Medical Education, commonly referred to as the Millis Report, has emphasized the need for continuing comprehensive care as a central focus of medical school organization, planning, and clinical teaching. It is my opinion that the most significant tool of the physician in any continuing and comprehensive approach to the patient is the medical interview and the psychotherapeutic relationship to the patient. Unfortunately, the past medical training of most physicians has promoted the concept of psychotherapy as being a technique applicable to a special group of patients, a method used by highly special-

ized psychiatrists, a procedure requiring long periods of time per visit and years of visits, being excessively expensive and as not applicable to the practice of physicians who see large numbers of patients with a diversity of medical, surgical and psychosocial problems.

The new body of knowledge needed for comprehensive medical practice is seen by the commission as coming from the disciplines of psychiatry, sociology, and public health. The background for that which is social and humanistic as well as biological is not well defined. What has been less distinct has been the philosophy, methodology, and techniques of a treatment approach applicable to comprehensive care. The following description is an outline of the psychotherapeutic approach which the author feels must be the base of the pyramid for the therapy of comprehensive care. The 10 to 15 minute contact of psychotherapy is the base of the pyramid, the apex of which is the direct, on-target treatment of the specific biologic dysfunction by the specific therapeutic agent.



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continuing education programs in psychiatry for non-psychiatrically trained physicians. Dr. Garner received his M.D. from the University of Illinois College of Medicine. He is also consulting at the V.A. West Side Hospital.

Brief psychotherapy lends itself to a broad spectrum of applications covering almost every type of health dysfunction described, and in almost every type of setting in which mental health therapies are offered. Specially designated groups such as college students, mothers, parents of children, teachers and psychologists have been treated with brief periods of psychotherapeutic contact. Treatment programs have been reported in settings such as inpatient units of general hospitals, psychiatric hospitals, outpatient clinics, social agencies, and medical clinics. The treatment of patients following the initial comprehensive interview must be dependent upon appropriate management for physical disabilities in keeping with medicinal, surgical and manipulative agents and techniques available.

The establishment of a psychotherapeutic encounter of 5 to 15 minutes can be the aim of any physician who is engaged in a practice which does not justify the use of 50 minutes as a psychotherapy unit of time. Although psychotherapists generally feel that a 50 minute unit of psychotherapy is more valuable than 10 minutes, and possibly correctly so, there is no scientific proof that 50 minutes will lead to better treatment results than 10 minutes. A period of 10 to 15 minutes may be acceptable to the non-psychiatric practitioner as one that can be realistically devoted to psychotherapy and as a period of time for which he can expect reasonable compensation without the patient feeling that he is being overcharged. In medical practice in which economic considerations are not significant, such as government supported medical practice, the pressure to take care of a reasonable caseload of patients in keeping with the demand for service would have considerable influence on the amount of time allocated to a particular patient for a series of weekly visits. I also find that when visits are frequent the tolerance level in a one-to-one relationship for most non-psychiatrists is about 10 to 15 minutes.

Patients who could use 10 minute psychotherapy, in my opinion, constitute some 60 to 80 percent of the patients commonly seen in the physician's office.

They include patients who have had an acute illness, yet continue to have symptoms although completely recovered from their physical disability.

Almost all patients with chronic illnesses

who show a reluctance to accept the basic medical care available for their illness, who seek "other answers," and who develop a "psychogenic overlay" such as an obsessive concern, intense anxiety or depression.

"Psychosomatic cases;" the patients included in the ulcer, asthma, colitis, hypertension group; patients in whom the illness is considered to have a significant etiologic relationship to psychologic and social stresses.

Patients with psychoneuroses, psychophysiologic reactions and psychoses who seem responsive to management of periods of acute distress without showing evidence of progressive disability and deterioration; who can be accepted for such treatment by the physician without a rejecting or condemning attitude or other unwarranted treatment approaches to the patient. The patient must be able to accept such a relationship without insisting that he needs specialty help from a psychiatrist and will accept such care without feeling unfairly used in being expected to pay for "just listening" or "just talking."

Realistic goals in treatment must be established and acceptable to the physician before he can learn to use 10 minutes of his time effectively for psychotherapy. The physician must accept Oliver Wendell Holmes' statement, "It is a physician's privilege to cure seldom, to relieve often, and to comfort always." We have become capable of curing frequently, and relieving almost always, since Holmes wrote the above quotation, but **many a physician remains unable to accept the fact that comforting is his most frequent goal** within the realistic limits of the problems presented to him, and his capability to help. For patients other than the individual with an acute illness with early recovery expectation, techniques are required to enable the patient to feel comforted, yet concurrently to discourage regressive needs for a dependent position. The management should encourage the patient to develop the capacity to transcend the problems caused by his illness and to help him acquire constructive rather than destructive and regressive tendencies.

The patient-physician relationship must be understood as an interpersonal interchange in which the physician is constantly aware of, and is evaluating and restricting the relationship in keeping with the needs

of the patient. Unfortunately for the patient, few healers or helpers of any kind are capable of sufficiently putting enough of their own needs aside so that the full measure of devotion to the task of helping the patient is available. However, if the physician can understand the interpersonal exchange in doctor-patient relationships described in the following models, he will be able to achieve a therapeutic stance closer to the ideal. The relationship described emphasizes the patient's behavior in response to the doctor's overt or implied interventions.

1. Compliance-without critical appraisal: "Anything you say goes with me. You direct and I will carry out the orders."
2. Compliance with critical appraisal: "I am basically ready to follow your orders, but they must make sense or you must give me a somewhat reasonable explanation."
3. Critical appraisal: "I am not assuming you know everything and I know nothing. You will have to give me the facts and I will then make my own decision."
4. Non-compliance: "I am ready to rebel against anything you say. I see you as a boss, authority or someone making me submit and I don't intend to do anything you order me to do or even suggest I do."
5. Non-compliance with critical appraisal: "I know what you are expecting me to do is wrong. My good sense tells me not to go along with you."

An initial history and interview, and the etiology, diagnosis, physical examination and laboratory evaluation are assumed to have been given the appropriate attention needed before the physician begins to see himself as primarily involved in a psychotherapeutic procedure. Furthermore, the physician assumes an alert posture to the possibility of revising his opinion about what is wrong with the patient. Careful listening with some deliberation will offer what in my opinion is an opportunity for enhancing etiologic understanding, diagnosis and treatment potential beyond that offered by any other available technical tool. Careful use of the laboratory will from time to time be necessary when its information will dispel doubts in the therapist's mind. No diagnosis is to be considered final once the psychotherapeutic relation-

ship is established, but neither is every complaint to be seen as a basis for "ruling out everything first" by immediate re-examination or by further laboratory exploration. Treatment should likewise not be altered at the first complaint of the patient in which he suggests an urgent need for immediate attention to a new problem. The chances are that a better perspective of what is wrong will come from attentive listening and an observing attitude in the next few visits.

After the initial history and evaluation, the treatment arrangement is established. The regime is outlined for drugs and other additive agents such as injections, manipulations, or subtractive actions (removal of a small tumor, etc.), and the patient is advised about the frequency of visits at a regular time-place, and with a time limit. He should either be informed directly about the time limit or learn it by the experience of having the visit time limit clearly evident by starting and ending promptly as scheduled. The exceptions, in which the emotional problem or physical problem of the patient can no longer be cared for within the arranged appointment, can be managed by informing the next patient of the altered schedule. There should be a positive statement made about the fee arrangement and the patient should not be made to feel by the physician's behavior and utterances that being paid for psychotherapy seems unusual or makes him uncomfortable. Offering the patient something in addition, such as a prescription or some samples, is avoided except for circumstances that may be in the best interest of the patient. Basic to all therapies is the willingness to accept the fact that dignity and respect must be accorded one human being by another. The physician must face any strong dislike for a patient and try to alter his attitude through understanding or refer the patient elsewhere.

The Ten Minute Visits

The first few 10 minute visits can be fruitfully utilized to obtain much of the psychosocial, family, and early life history of the patient. These visits are not only useful in obtaining historical data pertinent to the patient's original difficulty but become a most significant educational experience for the physician wishing to learn

about the many predisposing, precipitating and perpetuating events and their causal relationship to psychophysiologic reactions. Questions such as "I don't know much about you," "Tell me about your health and experiences as a child," "Did you attend grade school in the city? Where? How did things go for you during that period of your life?" are but samples of many that can be used to develop an excellent medical and psychosocial history which will aid in developing the understanding of the themes which run through the patient's communication with the physician. The onset and course history of the initial interview should offer an opportunity for information gathering in which details are elicited about the when, where, how, why, which may be explored in the 10 minute visits of the patient to the relief of the patient and the satisfaction of the physician.

The subsequent visits with the patient are used for furthering the benefits to be obtained from psychotherapy. Simultaneously one is alert to information which may help diagnostically or which reveals any significant change in the physical state of the patient. Clues will appear to whether anxiety and other troubles warrant increasing the frequency of visits, or whether improvement would suggest the need to terminate the visits, or decrease their frequency. A minimum of reference to the patient's symptoms is desirable. Repetitive questions directed at eliciting information about symptoms are usually interpreted by the patient to mean that the physician intends to be *selectively attentive to symptoms*. *The need to please the physician will be associated with a tendency to communicate on the level of "I am suffering physically as you can see by my symptoms."* When necessary, by phrasing questions in an indirect manner, the physician may be able to elicit the information he may require for reassuring himself that the patient's "original" problem is not being overlooked. For example, a patient with a gastric ulcer has been seen once every two weeks and has usually been relating material about his work, family and the pressures and the aggravations he has encountered. During one visit the physician is impressed with the patient's seeming pallor and seeks information and communicates to the patient. It is preferably not as follows—"How often are you having these pains in your

stomach now?" "Have you had any tarry stools lately?" "You must be bleeding lately; get a count immediately." Indirect questioning will usually elicit as much information; will be less frightening to the patient; and will not create the programming of the patient for regression and the sick role. The preferable approach suggested is, "You know that during your last few visits you haven't said anything about the problem which originally brought you to see me. Have you noticed anything about your stomach? How is your appetite? Have you noticed any distress with regard to food? What about your bowels? Have you noticed anything unusual about them?" Toward the end of the visit the patient might then be told, if the physician remains uncertain about gastric bleeding, "You seem to be feeling quite well but I usually take a blood count from time to time after such an illness. Will you please stop by the laboratory so we can check yours?"

Selective inattention to physical symptoms—listening with a minimum of clues to the patient that "he thinks this is so important"—and indirect questioning about symptoms will tend to enhance the treatment relationship. Selective attention to life's experiences, events, emotionally disturbing circumstances which tell about how the patient is living and about his personality and behavior will encourage attempts by the patient to understand the problems of life and the desirability of looking for solutions through methods other than the "sick role."

A listening, non-condemning, non-judgmental attitude is basic for the visits. Being humane, patient, having a realistic (humble) opinion about one's importance for the patient, yet being capable of recognizing the patient's need to endow the physician with God-like qualities is essential to effective psychotherapeutic work. Where the patient communicates freely so that few if any interventions are necessary by the physician, the 10 minute visit might start with "How have you been?" "What is on your mind?" and end with "It seems your main trouble was your boss," or it may end with "You look well; I will see you January at" Sharpening the technical tools utilized for the material being assimilated during the ten minute visits will take place as the therapist learns

more about his most valuable therapeutic agent—the patient's actual evaluation and his fantasy of the physician as a person.

Questions are a constant feature of psychotherapy. They should be used as an invitation to further collaborative exploration of the patient's difficulty. They should tend to stimulate a desire to seek out motivations and hidden factors and lead to an illumination of unacceptable ideas, thoughts, and behavior. "Why?"—"For instance?"—"Tell me more about that?"—"How do you feel about that?" Listening, questions, selective inattention, and selective attention may be all that many patients will require during the 10 minute visit. However, in such restricted intervention therapy, the patient may be waiting for the magic solution which never comes. Eventually this may express itself as hostility toward the physician who is seen as having failed or having displeased the patient.

Elaboration on what the patient doesn't say. Shame, guilt, pride may act to minimize the expression of thoughts and feelings which would add to understanding of the patient's discomfort and could act as a therapeutic cathartic and ventilating experience. Elaboration may be encouraged by appropriate questions. "Was there something about the closeness of your relationship to your friend that troubled you?" may bring a flood of material dealing with guilt feeling over what the patient saw as a sexual transgression. The tendency to circumstantiality, a shy discussion of a subject, an allusion to "what's the use of it all," are examples of the cues which may be detected in a 10 minute interview, which may require elaboration on what isn't being said. The use of the cue through appropriate questioning adds another dimension to the therapeutic work: catharsis and ventilation in a non-condemning atmosphere diminishes anxiety, makes realistic evaluation possible, and therefore, encourages problem solving thinking in the patient.

Inquire into the patient's daily activities. The patient may have expressed boredom, dissatisfaction with ability to accomplish or do things, lack of interest in the usual day to day happenings. Questions directed at accounts of the patient's daily activities may reveal evidence of compulsive concern with detail and husband-wife disunity, and because of their fears about raising

children and difficulties with in-laws. These represent a few of the possibilities for encouraging the patient to feel that the 10 minute period is being used for his or her benefit. The therapist's inquiries may: awaken doubts about and a desire to explore the compulsive house-cleaning tendency; bring out the reason for failing to call her husband's attention to the fact that the family social life has been totally neglected; or establish that since the child was born the mother is indecisive about being able to mix the formula properly or about being sure if the baby is being fed properly. "It seems as though it takes up a good deal of your day just to take care of the baby's formula" may be the question that may bring out the mother's doubts about making it just right, repeatedly checking with her pediatrician about details, and being distraught about the danger to the baby if his formula isn't just right. The patient may be able to benefit therapeutically by the inquiries into the daily activities by being encouraged through the inquiries into wondering why she doesn't do more to make life more satisfying and why she doesn't take the steps which she has expressed would lead to more satisfaction.

Reassurance tends to alleviate anxiety through giving moral support to a viewpoint or action, suggesting and directing the patient into channels of behavior and attitudes which correct a fault, diminish the need for guilt feelings and encourages constructive realistic achievement. Being reassuring when the patient sees such reassurance as being meaningless is detrimental to the value of the 10 minute visit. It is best to convert continuous requests for help—a request for reassurance into—"You apparently have doubts about what can be done for you; I wonder why?"—whenever the patient tends to compulsively request reassurance by—"Can I be helped, doctor?" One can alleviate the patient's lack of self esteem, one of the more common problems of the patient, by a reassuring question—"Why is it so easy to minimize your accomplishments or personal worth?"; in response to—"Was what I did right?"; this in itself is a major source of reassurance. When the patient should be reassured about the absence of disease, and the findings warrant it, the reassurance should

be unequivocal. "My examinations **show no** evidence of cancer. You have asked me—'could it be I have cancer?'—several times. You apparently doubt my opinion; I wonder why." Remarks such as, "You don't have any cancer, but no one could be 100 percent certain," or similar statements in which you express uncertainty are usually undesirable.

Advice is something easily come by and often given freely by friends, next door neighbors, etc. The physician may fall into the trap of being constantly giving advice about matters in which he is neither qualified nor about which he should give advice. Use the 10 minute visit for altering the patient's need to see himself as not knowing the answer to questions asked, and to not see the physician as an all-knowing omniscient agent of God. Establish the significance of the frequent request for advice by an exploratory question. "You continually ask my advice; I wonder why you should feel you—don't know—are incapable of—are unable to learn about—when in fact you do know—etc." One may also respond to the frequent tendency to convert doubting and indecision into requests for advice. "You ask me about divorcing your husband, but you yourself have expressed many doubts about such a move. You apparently doubt the advisability."

Clarifying interventions in which educating and informing is the goal of the interventions may be most valuable for the patient when in truth the physician can educate or inform and the patient's lack of knowledge or difficulty in comprehending relationships, or failure to express something in a precise manner is involved. Feelings, thoughts, impulses, behavior and reaction patterns stated imprecisely may be recorded and clarified—"I gather from what you say that you feel that your husband's temper is provoked by you, yet you say you are afraid of his temper." The patient may be given information which he could not ordinarily be expected to know—"Taking an electrocardiogram could not in anyway lead to a change in your treatment." Interventions such as—"I don't quite understand"—"I don't see the relationship"—"You tend to relate your headaches to the argument you had with your boss"—"It seems you may be more accepting of the fact that you don't have some-

thing seriously wrong with your brain than you have been willing to admit"—are examples of statements intended to clarify.

Persuasion and authoritarian commands may be necessary where it is clear that the patient, in feeling a loss of control of impulses, is pleading for restraining external authority. When this seems necessary and the presentation of logical arguments seems a possible basis for influencing the patient, the 10 minute visit may have had important psychotherapeutic influence through persuasion. To be effective, one must have been accepted as an authority of prestige, credibility and knowledge. The commanding or forbidding of dangerous or destructive behavior to self or others is usually best carried out as a confrontation followed by the question—"What do you think or feel about what I told you?"—repeated frequently. "You should stop acting like a child with a temper tantrum. What do you think or feel about what I told you?" Persuasion as a means of converting the passivity of the patient and the fear of self-assertion into an expression of self-assertion is usefully applied to helping the patient with feelings of insignificance or fear of self-assertion. This is frequently a displacement from a fear of aggressiveness that is unwarranted. "What is there about being assertive which frightens you?" During the visits, the repetition of such a question may help convert the patient's passivity into constructive self-assertion through exploring the basis for the lack of self-assertion and concluding that the non-assertive position could be changed to a more positive approach without danger.

Suggestion is used when the physician finds it desirable to create a compliant attitude toward a particular assertion or statement made. Assent without reflective thought is the expected response. Suggestion is part of a continuum of influencing relationships in which assent is expected from the patient: hypnosis in deep trance, states of relaxation, direct influence of an authoritarian nature without trance are all states of compliance and are associated with perceptions, thoughts and behavior characteristic of the person who assents to what the other individual indicates is a desirable course of action. During the 10 minute visit, the use of suggestion can be best accomplished by intervening in the patient's

conversation by exploratory confrontation questions which the patient, because of his needs, may use as if they were suggestions. For instance, "What is there about getting married that should be so upsetting?" would be more desirable than "You should get married. I've met your girlfriend and she is a fine girl." The first approach encourages exploration without giving the patient the feeling that he has some basis for anxiety, and that he has been given an evaluation of the girl as "the right one" which is not usually warranted by the knowledge available to the practitioner about the couple.

The confrontation problem-solving technique of making a statement directed at altering repetitive patterns of perceiving, thinking, behaving and communicating can be used when simpler techniques have failed to favorably influence the patient. The statement is repeated once or twice during the course of the patient's visit and is followed by the question—"What do you think or feel about what I told you?" A patient who reiterates a concern with physical disease of a malignant nature might, for instance, be told—"Stop believing you are suffering from a dread disease. What do you think or feel about what I told you?" Repetition of the statement and the question or the question alone is a must in subsequent visits, usually carried out at a fixed interval and for a fixed period of time.

The next step in using 10 minute contact for beneficial psychotherapy is to de-

velop a therapeutic focus. A therapeutic focus is used as a basis for symptom control or symptom removal, and/or, if the physician becomes more skillful, as a therapeutic effort to improve the capacity of the patient to cope with his problems more effectively. For example, in the depressed patient such a focus may be the patient's hopeless outlook on the future. The therapeutic focus as the concept for establishing the work of the 10 minute visit would best be discussed in detail in another issue. With a basic outline of the psychotherapeutic 10 minute contact, however, the practitioner may proceed to work with the patient for a few visits; many visits followed by periods of interruption of treatment continuity; or treatment interminable, with periods of increasing the time between visits and other arrangements to decrease dependency.

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Achievement

Achievement is usually expressed in the satisfaction that comes when one feels he has accomplished something worthwhile—maybe something he had considered an impossibility. It may come after a long series of failures. The case is reported of a young man who came to Edison greatly depressed, saying that he had tried two million ways to solve a problem, but had failed. Edison advised that this was indeed an achievement; "Now you know two million ways that won't work." Maybe one has succeeded in penetrating what seemed the impenetrably thick hide of a superior or a subordinate and received a favorable response, or he was successful in having a budget approved for items badly needed but which had previously been turned down by administration. Or, was it the time when he left on vacation with the expressed assurance of his assistant that his efforts to run a "taut ship" had put together a crew that could now function at top level even during his absence? (Clarence M. Ferguson, *Professions, Professions, and Motivation. JI. Amer. Dietet. Assoc.* [Sept.] 1968; 53:3; pgs. 197-201.)



ILLINOIS ASSOCIATION OF THE PROFESSIONS

IAP Officers in 1969

Newly elected officers of the Illinois Association of the Professions for 1969 include: Franklin P. Lee, R.Ph., president; Walter H. Sobel, F.A.I.A., president-elect; Harold I. Levine, LL.B., secretary-treasurer; Walter D. Linzing, P.E., Eugene L. Vickery, M.D.; Joseph Brophy, D.D.S.; and Ronald Kolar, D.V.M., vice presidents. New members of the board are Paul Flood, P.E. and Paul Schnurrenberger, D.V.M.

Interest in Con-Con

The board of directors has interested itself in the coming constitutional convention and is suggesting that delegate selection should be on a non-partisan basis. Attention has also been focused on matters pertaining to tax legislation as it relates to the individual and on professional services rendered.

AAP Meets

The Inauguratory Session of the American Association of the Professions was held at the Detroit Metropolitan Airport Hotel

*In spite of difference of soil and climate,
of language and manners, of laws and cus-
toms,—in spite of things silently gone out
of mind, and things violently destroyed,
the Poet binds together by passion and
knowledge the vast empire of human so-
ciety, as it is spread over the whole earth,
and over all time*

—William Wordsworth

on Saturday, February 22. The second session was to convene in Spain. Board members planning to attend the Detroit meeting were: C. Dale Greffe, P.E.; George B. Callahan, M.D.; Eugene L. Vickery, M.D.; Franklin P. Lee, R.Ph.; and Martin Sopocy, R.Ph. Dr. and Mrs. Vickery, Mr. Lee and Mr. Sopocy made the trip to Spain.

Miscellany

The Illinois State Veterinary Medical Association held its 87th annual convention at the LaSalle Hotel in Chicago on February 23-25, 1969. A fine program was arranged.

Pictured with IAP president, Franklin P. Lee, R.Ph., are executives of member organizations. Together at a recent meeting of the IAP executives were (from left): William J. Greek, D.D.S., Illinois State Dental Society; Roger N.



White, Illinois State Medical Society; Jeannette M. Cochrane, Illinois Society of Certified Public Accountants; Franklin P. Lee, R.Ph., IAP president; Clarence B. Hostetler, D.V.M., Illinois State Veterinary Medical Association; William E. Dart, Illinois Society of Professional Engineers; Richard S. Strommen, R.Ph., Illinois Pharmaceutical Association. Missing from photo is Wilbert Hasbrouck, Illinois Council of the American Institute of Architects.

Clinics for Crippled Children Listed

Twenty six clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. Nineteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service will be conducted. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

April 2—Alton Rheumatic Fever & Cardiac—Alton Memorial Hospital

April 2—Rock Island Cerebral Palsy—3808 Eighth Avenue

April 2—Hinsdale—Hinsdale Sanitarium

April 3—Lake County Cardiac—Victory Memorial Hospital

April 3—Flora—Clay County Hospital

April 8—East St. Louis—Christian Welfare Hospital

April 8—Peoria General—Children's Hospital

April 9—Champaign - Urbana—McKinley Hospital

April 10—Springfield General—St. John's Hospital

April 10—Macomb—McDonough District Hospital

April 11—Evanston—St. Francis Hospital

April 11—Chicago Heights Cardiac—St. James Hospital

April 15—Quincy—St. Mary's Hospital

April 15—East St. Louis—Christian Welfare Hospital

April 16—Chicago Heights General—St. James Hospital

April 17—Elmhurst Cardiac—Memorial Hospital of DuPage County

April 17—Bloomington—St. Joseph's Hospital

April 17—Rockford—Rockford Memorial Hospital

April 23—Metropolis—Massac Memorial Hospital

April 24—Cairo—Public Health Building

April 25—Chicago Heights Cardiac—St. James Hospital

April 29—Belleville—St. Elizabeth's Hospital

April 29—Peoria General—Children's Hospital

April 30—Springfield Cerebral Palsy—Diocesan Center

April 30—Mt. Vernon—Good Samaritan Hospital

April 30—Aurora—Copley Memorial Hospital

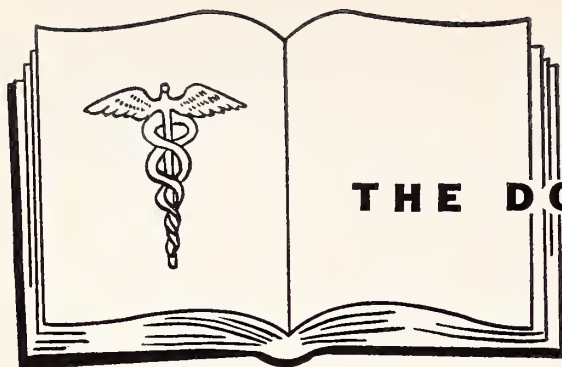
The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

Coronary Artery Spasm

In a series of 750 coronary cinearteriograms, coronary spasm was observed in only seven individuals. At the time of the cinearteriogram, three experienced an attack of chest pain that had all the features of coronary insufficiency before the spasm was relieved by nitroglycerin. One of these three patients displayed an acute myocardial injury pattern on the electrocardiogram, another one went into cardiac standstill which responded to external massage.

Coronary spasm is probably due to the action of catecholamine on the alpha receptors of the large coronary vessels, whereas myocardial anoxia can still be considered the immediate cause of the cardiac pain. Differences in the symptomatic manifestations occurring during coronary spasm may be due to the degree of arterial narrowing, to the presence or absence of coronary artery disease and also to individual differences in pain threshold.

Whatever its final mechanism, coronary spasm, may, in an occasional individual, be responsible for an attack of angina pectoris and even for sudden death. (Coronary Arterial Spasm. M. A. Demany, A. Tambe, and H. A. Zimmerman. *Diseases of the Chest*. 53:6 (June) 1968, ppg. 720-721.)



THE DOCTOR'S LIBRARY

MANUAL OF PREOPERATIVE AND POSTOPERATIVE CARE. Edited by the Committee on Pre- and Postoperative Care, American College of Surgeons, H.T. Randall, J. D. Hardy, F. D. Moore, Editorial Subcommittee, Published by W. B. Saunders Company, Philadelphia, 1967.

The goal of this book, as stated in the introduction, is to "provide a useful outline for modern methods of handling the major problems of preoperative preparation and postoperative management of patients undergoing both elective and emergency surgery." The book is comprised of 36 short chapters, plus an Appendix. Approximately 30 different authors contributed to the book, all of whom are acknowledged leaders in their respective fields and represent 23 different medical centers. One can appreciate the difficulties of the editors in organizing this book. The book is dedicated to the late Dr. Champ Lyons, who initiated the project.

The accuracy of the word Manual in the title of the book becomes apparent as one reads the book. The chapters are concise and areas of controversy are presented in a rather dogmatic fashion. There is a brief bibliography at the termination of each chapter, and usually the references are to the standard surgical texts. This is disappointing, because many would appreciate reference to articles in the recent surgical literature which this distinguished group of authors would consider significant.

The quality of the material in the book is excellent. The volume of information that has been compressed into 476 pages of text is impressive. The book should find a particular audience among house officers and busy practitioners who seek a brief, accurate clinical discussion of preoperative and postoperative problems.

Paul H. O'Brien, M.D.

ULTRASONICS IN OPHTHALMOLOGY. Richard Earl Goldberg, M.D., and Lov K. Sarim, M.B., W. B. Saunders Company, Philadelphia, 1967, Illustrated, 223 pages, \$24.00.

Scientific ophthalmology may be said to date from 1851 when that great physiologist and physicist, Helmholtz, invented the ophthalmoscope. This set a pattern for the succeeding years in that each new development in instrumentation and technology was avidly grasped by ophthalmologists to improve their diagnostic and therapeutic abilities. Examples might be the xenon arc, the laser, cryogenic apparatus, etc. A more pertinent example is the subject of this textbook, ultrasonics. Although the fact that certain crystals will give off high-frequency sound waves (above the audible, or ultrasonic) when electrically stimulated was first discovered by the Curies in 1880, it was not until 1937 that this principle was used to detect internal flaws in metals. From this the application to medicine proceeded rapidly and in the post-war years the use of ultrasonography in ophthalmology has mushroomed. Its prime function is still the demonstration of masses in the eye with opaque media or of masses in the orbit. A minor use is for the determination of the axial length of eye structures.

The editors of this monograph have gathered papers from various laboratories in this country and abroad and have collated them into an orderly presentation of the theory, the instrumentation and the diagnostic uses of this modality.

Familiarity with this text is a prerequisite for anyone wishing to develop an ultrasonic laboratory for diagnostic use in ophthalmology, or for that matter in other specialties.

David Shoch, M.D., Ph.D.

HANDBOOK OF FRACTURES. Edgar L. Ralston, M.D., C. V. Mosby Co., St. Louis, Mo., 1967, 286 pages.

This excellent handbook was written especially for medical students, and covers the treatment of practically all fractures in a clear and concise manner. Unfortunately, however, unless medical students have changed radically in the past few years, this book will probably never be sold in sufficient quantities to justify its stated purpose, since few medical students are sufficiently interested in fracture problems to be induced to purchase such a book. While the book does cover many details of fracture care, it does not go into the treatment of fractures in sufficient depth to serve as a source book for the practicing physician.

The first section of the book considers the general principles of fracture care, including healing of fractures, delayed and non-union, the general tenets of fracture care and complications of fractures, including open fractures, injuries to major nerves and vessels, infections, hemorrhage and shock and fat emboli.

The remaining portion of the book is devoted to regional consideration of specific fractures, and includes excellent sections on fractures of the skull and facial bones. At the conclusion of the consideration of each fracture, additional reading references are given to guide one's further study of specific problems.

The book is well written, and merits wider circulation than it will probably receive. It is to be recommended to all medical students.

David C. Bachman, M.D.

SYMPOSIUM ON GLAUCOMA. Transactions of the New Orleans Academy of Ophthalmology. The C. V. Mosby Company, St. Louis, 1967. 306 pages, 120 illustrations, \$17.50.

Glaucoma continues to be a fascinating topic to most ophthalmologists, perhaps because some order has developed in recent years in our understanding of the pathogenesis and treatment of this disease. This book (a transcript of a symposium held in New Orleans in February, 1966) is particularly valuable since the participants are in large part the people responsible for this advancement in our knowledge.

For example, Zimmerman discusses the histology and pathology of the outflow channels, Armaly reviews steroids and glaucoma, Shaffer discusses miotics, Becker presents recent data on the treatment of glaucoma with topical epinephrine and systemic hyperosmotic agents, etc. These and other papers occupy the first half of the book. Perhaps of even more value is the second half of the book which is a transcription of round-table discussions whose participants were those listed above plus Kronfeld, Haas and Pollack. These discussions alone are worth the cost of the book, since the material is somewhat controversial and in no other place have the simultaneous opinions of so many experts been put on record.

This symposium is highly recommended to all ophthalmologists who desire a better understanding of glaucoma which in actuality means eye men of high and low degree.

David Shoch, M.D., Ph.D.

Film Review

A film of interest to medical students, residents in psychiatry and pediatrics, nurses, psychologists, and professional staffs of hospitals for the mentally ill or retarded children, is entitled "The Headbangers." This demonstrates the problem of self-destruction behaviour, specifically focusing on pathological headbanging. The film depicts several institutionalized children who manifest self-destruction behaviour through this symptom. The possibility for treatment for what has been generally considered "hopelessly intractable behav-

iour" is seen in changes which occur in one of the subjects. Persistent, cooperative effort of the staff and therapist is the primary mode of treatment emphasized. "The Headbangers" was produced by the National Institute of Mental Health in cooperation with the Sonoma State Hospital in California in B/W, 16 mm. sound. Running time 30 minutes. It is available on free, short-term loan from the National Medical Audiovisual Center (Annex), Chamblee, Ga. 30005.

Abortion—A Catholic View

BY CHARLES J. CORCORAN, O.P./DUBUQUE, IOWA

The Roman Catholic Church has no magic way of arriving at moral decisions, no deductive system of morals which supplies the answer to a given medico-moral question before the problem is met and solved in real life. The church is no know-it-all organization. The findings of science and the inventions of art and technology come as a pleasant and bountiful surprise to the church as to the rest of men. The church is no more a seer of future moral problems than it is of the discoveries and inventions, the new political, economic and social forms which demand new moral answers.

And when these unforeseen moral questions do arise, the church has no ability to decree their resolution in haughty isolation. It must collaborate in finding the answer through public discussion, with confidence in the conscience of society. On some issues society will form its conscience primarily in and through the professions, which are the organs of society in matters requiring great knowledge and skill. The church must share the common trust in human freedom as a self-purifying stream. The public at large may think wrong, said Ernest Barker, but if given enough time it tends to think straight. Or, as Abraham Lincoln put it, you can fool all of the people some of the time and some of the people all of the time, but you cannot

fool all of the people all of the time. For grave moral decisions such as we face in the area of medical practice we must rely on this self-purifying mainstream of public freedom in society at large or within the professions which represent society. To remain self-correcting, however, human freedom needs boundaries which, like the banks of a river, maintain a clear channel and free flow. Even a virtue, if driven beyond its proper bounds, turns into a vice. Some of the greatest evils in the history of man have been done 'for the other person's own good' by a love acting out of bounds. The boundaries cannot be set by an autocratic individual nor by an elite minority. They must be arrived at by public discussion, be accepted freely by the conscience of society aided by its professions, and be open to reassessment with the increase of human knowledge and the change of human needs.

For every freedom which we claim we must specify its boundary conditions if that freedom is to be assured. Without the secure boundary set by the commandment 'Thou shalt not kill' one could never be so free in sharing his life with his fellow man. Without the limits set by the commandment 'Thou shalt not steal' one could not ever be so free in sharing his possessions. By excluding actions which are out of bounds the commandments protect the endless alternatives of positive action manifested in our verdant variety of human cultures and in the life-styles of unique individuals.

The problem of abortion raises the question of boundary conditions for the most basic freedom of all, freedom to life itself, without which no other value or

This is the last in a series of three papers presented at the symposium on abortion at the 1968 ISMS Convention. The first paper, in the January Journal, was presented by Rabbi Martin J. Goldman and was entitled "Abortion: Jewish Law and the Law of the Land." Last month Rev. Charles Carroll, Chaplain to Faculty and Students, the University of California presented "Liberalized Abortion—A Precedent Shattering Precedent." Rev. Corcoran, this month's author, is from the Aquinas Institute, Dubuque, Iowa.

freedom is possible. Are there limits to what we can do in dealing with a human life? Can the value of human life and our freedom about it be preserved if we surrender or enlarge the boundaries now embodied in the laws of our land? Is there room for negotiation or compromise in this matter? Is it a matter to be decided by the individual or does the community have rights in the life of the unborn child? Is it moral to legally compel a woman to carry a child whom she did not voluntarily conceive? Are the rights of life vested only in persons, and is the child a person only after birth or at least only after viability? Can the fetus be done away with as an aggressor 'in pursuit of the mother's life?'

The answers to these questions are by no means foregone conclusions. Rigid, stereotyped behavior, that 'foolish consistency which is the hobgoblin of small minds,' is the farthest thing from the moral law. The moral law is simply man's obligation to be true to himself, to his human nature, by acting humanly and humanely, that is, reasonably and with proper feeling. There is a regularity to moral behavior, but it is a regularity which admits of every reasonable exception. The moral law may demand one thing regularly and yet on occasion demand the opposite. Ordinarily we must return property to its owner, but not a gun to a madman. The moral law may demand the preservation of life ordinarily, and still allow killing for self-defense or defense of the innocent. Again, the preservation of consciousness is demanded ordinarily, although suppression of consciousness is the moral thing when total anesthesia is medically indicated. The norms of morality continue to be based on nature, not as ideally conceived in some Platonic manner but as actually encountered by man in his efforts to act humanly.

Thus, we can have no rigid, stereotyped norm about abortion. As reasons for abortion seem to arise they must be sorted out in public discussion. The discipline of discussion demands that each reason be advanced on its own proper merits, not under cover of some other. And when the reasons alleged for abortion are honestly stated we find that a solution emerges which does not demand the direct termination of pregnancy. Economic problems find an econom-

ic solution, psychological problems a psychological solution, and so forth, each problem finding an answer from the appropriate professional source. Nowhere do we find the taking of innocent human life as a proper solution. We do not solve the problems of poverty by killing the poor.

Every moral judgment is contingent upon the empirical facts of the case. Foremost in the present instance is the fact of human life itself. Our problem is not the regard we have for human life so much as it is a matter of what we define as human life, what we look upon as a human person. Death has been easily dealt to whole races of men by fellow men who defined them as less than human. Surely, abortions could be occurring in the scores of millions only if the conceptus were being defined as less than fully human. But is this definition valid?

The life of the individual within the womb is controlled not by the genetics of the mother but by the genetics of the resident of the womb. The mother provides nest and nourishment for the genetically independent life within her. Science knows of no interruptions or discontinuities in the advance through all embryonic and fetal stages, through birth, puberty, adulthood and senescence. Science knows of only one continuous and uninterrupted human life, one single identity from the moment when the genetic endowment of sperm and egg combine to initiate a new and distinct series of activities and receptivities. There is no scientific basis for saying that personhood is not present from that moment on. The person is the living organism. There is no scientific foundation for drawing any distinction between the human person and the organism which begins life at conception except to differentiate stages of a single growth process. To destroy life within the womb at any time from conception onward is, therefore, to take the life of an innocent human person. The direct taking of innocent human life is not a medical therapy nor a cure for the social or economic problems of childbearing, and it cannot be made so by law. Legalized abortion might be a declaration by legislators. It could never be law.

This is not to say that the problems whose solution is sought in abortion are not all too real and heartrending. The

professions have the further duty of addressing each such problem and seeking a moral solution. Enough has already been done by the professions to render the phrase 'therapeutic abortion' anachronistic or completely doctrinaire.

To those who would justify the direct killing of the fetus as a 'material aggressor' 'in pursuit of the mother's life' Drs. Hefernan and Lynch have replied: "Anyone who performs a therapeutic abortion is either ignorant of modern medical methods of treating the complications of pregnancy or is unwilling to take the time to use them. . . . As far as a complicating disease is concerned, the expectant mother presents a problem not greatly different from that of a non-pregnant sister with the same disease, and furthermore, so far as her pregnancy is concerned, she is not greatly different from other pregnant women." In their home metropolitan area of Boston, in 1957, there were 16,325 babies born without a single maternal death. One hospital registered 20,000 births without one maternal fatality.

With organic pathology removed as a justification for abortion we find psychiatric reasons being used more and more. To this point Dr. Myre Sim, a British psychiatrist writes: "There are no psychiatric grounds for the termination of pregnancy

. . . . If society wants abortion to be easier, it should have the courage to campaign for it honestly and not exploit the psychiatrist, who, I contend, has no factual basis for being associated with the problem."

To the mother who would complain that her rights are being violated if society denies her the power to terminate the life in her womb we may respond that the community is equally primary with the individual. No man is an island unto himself alone. Intersubjectivity is part of each human being's basic reality, carrying with it a complex of intersubjective rights and obligations. Society as well as the mother has rights in her life and in the life in her womb. The community has the obligation to safeguard those rights and to guarantee the rights of the unborn child itself by vouchsafing equal protection of the law when the life of that unborn child is threatened, from whatever source.

We might continue thus through the entire inventory of arguments for abortion. The conclusion to emerge from the encounter of the various professions in the dynamic of public discussion would, I think, be the same: the inacceptability of direct abortion as an appropriate measure from any professional or moral point of view. ◀

Medicine and Religion Booklet Available

The Committee on Medicine and Religion of the ISMS has developed a booklet entitled "What Every Doctor Should Know . . . about the religious needs of his patients." This attractive informative booklet will be distributed to all hospital nurs-

ing stations in Illinois and to all chaplains' offices. For your copy and for additional copies for your clergyman fill in and return the coupon below. Limited supplies are available.

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Scientific Advances

The theme of the hundred and thirteenth annual meeting of the British Association for the Advancement of Science, held in Dundee in August, was modern man and the way he lives. Dame Kathleen Lonsdale, professor of chemistry at University College, London, and first woman president of the Association, entitled her presidential address "Science and the Good Life." She reflected that life in prehistoric and medieval times was not one long ecstasy, but she had to admit to an occasional night marish fear that all her life's work had been wasted and that science is, if not a monster, at best a victim of man's determination to destroy himself and his inheritance. She declared that most scientific and technologic debris is ugly with such horrors as slag heaps, hideous mining districts, detergent foams on little streams, tar and oil on the beaches, sulfurous fogs, waste papers and tins, smells and noise—and especially noise!

Surely, scientists could not wash their hands of these horrible consequences of the commercial aspects of their work. (John Lister. Modern Man. New England JI. of Med. [Oct. 31] 1968; 279:18; pgs. 985-987.)

Gauntlet to the Med Schools

(Continued from page 234)

lack a regular source of medical attention.

Four years ago the 31 southernmost counties of Illinois were shown to have only one physician per 1,400 inhabitants—a mere one-half of the recommended ratio. The shortage there is apparently even worse . . . **now**.

But no area of our state is in medical clover.

In Chicago, the number of MD's has shrunk from 6,300 in 1930 to 4,100 today—although the city's population has risen since then by 200,000. In the Woodlawn District of the South Side, the shrinkage over that period was from 122 doctors to 44. There was a comparable loss on the West Side.

Time does not answer the complaint that large sections of our population—particularly the "ghetto" poor—are neglected. Racial rioting helps show the impatience.

Time cannot heal the loss of health—and life—in the rural heartland of our state.

Time will not raise Illinois from 18th place in the ratio of MD's to population. On the contrary, other states are gaining on us.

Time cannot answer the fact that 12 other countries have higher life-expectancy rates than America . . . that 14 other nations, including all the industrialized ones in Europe, have a lower infant-mortality rate.

Time does not answer America's immediate need for 50,000 more physicians.

America's only real solution to the problem is to train more doctors . . . **now**. In Illinois we must not only train more, but **retain** them after their graduation.

We cannot depend on substitute devices and gimmicks.

We cannot depend on a continued inflow of foreign doctors.

We cannot depend on fieldshers, or assistant doctors. As the health-care crisis deepens, these could easily overstep their lines of authority and knowledge—and then we'd have a whole new sea of troubles.

Nor can we depend on the Federal Government to do the job for us. We cannot wait for some fancied medical West Point to pour shining columns of doctors into our midst. Some observers profess to see

hope in the Health Manpower Act of 1968. But it does not tackle the problem hard enough or directly enough.

No, the harsh, bitter problem lies squarely with us—right at our ivy-covered door.

Back in 1934, I was one of about 580 medical graduates in our state. Last year the total was some 40 fewer, although the population of Illinois has grown by 2 and 1/2 million since my sheepskin days. Nationwide, there was a modest increase—from 5,035 in 1934 to 7,970 last year.

Not only does Illinois lag in the training of doctors, but in the retention of those it does train. As the Campbell report noted: "In 1965, Illinois graduated 6.8 per cent of the physicians in the United States but licensed only 3.6 per cent of the new additions to the field of medicine in 1966."

They left mainly because we defaulted—in internship, residency and continuing education programs.

Let us not pretend the public fails to realize our academic failures. As Dr. John L. Parks, of Washington, D.C., said: "It is difficult for the public and legislators to understand why medical center faculties have expanded while the number of medical school graduates has increased at a disproportionately slower rate."

Dr. Parks—mind you—is a past president of the Association of American Medical Colleges.

REASONS FOR THE FAILURE OF MED SCHOOLS

Just how has our system of medical education failed?

Well, let's trace the system from the time a student applies to the time he enters practice.

America's medical schools seem to abide by the proverb that many are called but few are chosen. In the 1967-68 year, our medical schools had 18,700 applicants and admitted only about half. Not counting the brand-new schools, they accommodated only 425 more first-year students than in the previous year. The U. of I. College of Medicine accommodated only five more.

Twenty years ago the U. of I. accepted the largest number of students in its college of medicine of any university in the United States. This is no longer true. The universities of Indiana and Michigan have pulled ahead of us.

Was there a lack of qualifications in the 9,000 applicants rejected by America's medical schools? Not by any reasonable standard, in most cases. Many who lacked a 3.5 grade average could have made up for it in zeal and dedication. Unlike the typical "A" student who leans toward a research or teaching career, the "B" or "C" student might be the very person to prepare for a family practice . . . put down roots in one of those communities where the need is desperate.

What does the fortunate approved applicant find when he enters medical school?

Well, he finds a vested interest in prolonging the curriculum rather than accelerating it. Instead of getting all-around knowhow in medicine, he finds himself immediately impelled into a specialty. Above all, he quickly realizes that his instruction is a secondary concern of the school. Its primary intent is to attract fancy grants for research. He seldom may see the many able professors who spend the bulk of their time in the research lab. The medical student accounts for only 40 per cent of the academic responsibility of faculties, according to a nationwide survey. In a word, the student may feel like a second-class citizen in his own medical school.

I liked what C. Clement Lucas, Jr., president of the Student American Medical Association, told the Association of American Medical Colleges last fall. Mincing no words, he said the enlightened SAMA member "sees the medical school not as a force in improving the total health care in this country, but as the establishment which seeks to perpetuate itself by adding another research project and another professor in order to get more funds from the Government."

Yes, 49 per cent of our medical school faculty members get all or part of their salary from federal sources. Research also pays for buildings, plant operation, equipment. It wears the silk hat . . . and teaching is scorned as old-hat.

Upon graduation, the student is likely to find that internships and residencies are centralized in a few locations. He will scramble for one of the limited number of intern openings in a university-connected hospital . . . and probably leave the state if he loses out. Other hospitals must depend on foreigners to fill such openings.

Our universities have been a party to

this centralization and smugness. Good internship programs in many Illinois towns have been allowed to die on the vine. Outside of Cook County, the only programs are in Peoria, Rockford and Decatur.

The town where a doctor serves his internship and residency is likely to be the town where he marries and settles down. It is tragic that Illinois has not been able to keep nearly as many physicians as get their medical schooling here. We rank lowest of all the states in ratio of physicians licensed against the number graduated!

So from the beginning to the end of his medical education, the setup seems almost calculated to curtail the number of doctors. I'm not charging willful intent. But I do charge gross complacency! I do charge laxity in the desire to remain snuggled in comfortable old ways!

The smug overemphasis on specialized training is one of the hardest blows of all. General practitioners are the doctors most seriously needed in city neighborhoods, small towns and countryside. Every family . . . every community . . . is dependent on this medical jack-of-all-trades who can deliver a baby, set a fracture, recognize an emotional ill or perform surgery. He is medicine's basic line of defense . . . the key figure in the proper distribution of health care.

Yet—as The Wall Street Journal observed—"Many medical schools view general practice with distaste and fiercely resist any attempt to attract students into the field. Indeed, at these schools students have almost no exposure to general practice because faculty members are nearly all successful and devoted specialists."

Let me not give the impression, though, that general practice is getting all the brunt of the medical shortage. The number of candidates for certification in general surgery suddenly has declined. Our country has only a fourth of the pediatricians it needs. And I could go on.

THE NECESSARY ACTION

Maybe by now you're ready to fling the gauntlet back to me, and ask for specific recommendations.

Well, I'm ready to give you some.

The first thing we have to do is realign our whole attitude. We have to define the purpose of a university—particularly a state university.

Is it a neat little cluster of buildings, with walls to the world? Is it a collection of private interests, existing unto themselves? Or is it a part of the warp and woof of the entire state . . . a part of the daily and immediate life of the people who support it?

The answer is obvious. We have a broad human mission—and we must serve it with more than lip service.

Once we grant that basic premise, we can more clearly design our course of action—and create more doctors for Illinois.

I know your Board of Trustees has endorsed the Campbell Report, and you are taking steps to implement it. This report—prepared for the Illinois Board of Higher Education—contains many illuminating facts and cogent suggestions on the medical shortage. But it's too kindly with time . . . it allows us to take too many breaths before we fully act.

In America, we tend to take comfort from the sheer existence of a good report . . . and from slow, pious efforts to comply with it. Let us not be lulled on the medical crisis.

We must realize that an emergency exists, just as in World War II . . . and that a crash program must be adopted, just as in that conflict. There was no foot-dragging then, no endless referral of papers and clucking of tongues. No, there was a full-scale, year-around training schedule . . . an intensified curriculum . . . a burning compulsion to turn out as many qualified doctors as possible in the shortest possible time. As a result, America's medical colleges produced 11,200 MD's in 1944—double the prior annual totals!

And these weren't makeshift doctors, either—they weren't the proverbial 90-day wonders. Many of them today are highly respected members of their profession. Indeed, a Yale University study of graduates from before, during and right after World War II showed no appreciable difference in abilities and career achievements.

Gentlemen, we have to regain the impatience of those days—and realize that a health-care gap as well as a world war takes lives!

Here, now, are some things the University of Illinois College of Medicine must do as quickly as possible—in fact, more quickly than seems possible.

It must admit far more students—set its admission quota higher than seems reasonable, and then use every trick of resourcefulness to meet it. It must admit not only “A” students, but earnest, dedicated “B” and “C” students. It must not shunt such boys and girls to foreign medical schools . . . to lesser U.S. schools . . . to other technical fields. We need them in our own state. The premium is not on the academic glitter of the applicant but on the health quality of Illinois!

How can the school accommodate more students?

Four ways to do it—without building a single new classroom—are:

1. More emphasis on teaching and less on research. This is fundamental.
2. Intensive acceleration of the curriculum.
3. Full-scale use of facilities the year around, including the summer months.
4. Use of off-campus facilities for clinical and practical training. This would further free classroom space.

To provide intern training for the increased outflow of graduates, you will have to make arrangements with more hospitals. You should make them with community hospitals, up and down the state. They need you, and you'll need them.

Let me elaborate on these ideas.

You can accelerate the curriculum by providing the first two years of medical training in the liberal-arts college—thus enabling the medical school to concentrate on advanced instruction.

During his med-school training, you can have the student work in clinical centers and with physicians . . . have him get on-the-scene insight into everything from public health to clinical practice.

Students work with DuPage County doctors in the preceptorship program cosponsored by Chicago Medical School and the State Medical Society. I know a few of your faculty members are interested in preceptorships, but there must be a groundswell of enthusiasm. Our neighbor—Indiana University—is recruiting clinical centers throughout the state in the education of medical students.

By broadening your medical campus to include the liberal-arts college and outside

health facilities, you can achieve a corresponding increase in classroom space—and enrollment.

And you'll have enough instructors—if you transfer some of them from the laboratory microscope to the blackboard.

I know you are taking steps to expand your internship program, but you must take bigger strides . . . you must recognize community hospitals as teammates.

No longer should we frown on the capabilities of these hospitals. As Dr. Edwin F. Rosinski wrote in the *Journal of the American Medical Association*, community hospitals generally are becoming "*sophisticated centers of excellence*. (They) can provide a wide range of patients for teaching purposes; therefore, students can be exposed from the most simple to the most bizarre diseases."

I already have emphasized the importance of internship and residency programs to the retention of MD's in Illinois. As the Campbell Report says, "The location of internship and residency training is the most important influence on ultimate location."

A well-coordinated, concerted program of continuing education also will encourage doctors to stay in Illinois and in their communities. One of the chief complaints of the small-town and rural practitioner is that he is too busy to keep pace with medical advances . . . too remote from the nerve centers of technical development.

You can relieve the problem by opening your resources to the practicing MD . . . by adding medical field demonstrations to your list of extension services . . . by giving seminars and practical instruction at community hospitals, clinics and the like.

You cannot do this piecemeal. You must do it all the time, and all over the state.

It may fill you with pride that your medical alumni are working all over the nation and the world. But among patients there is grief—grief that more of these doctors aren't in Illinois.

WHAT ISMS CAN DO TO HELP

The ideas I've expressed are not white-

clouded illusions. They are realistic answers to harsh realities.

I know I've given you a mammoth order to fill. We at the Illinois State Medical Society stand ready to help you deliver.

We have a committee on continuing education, which we have described as "one of the basic purposes" of our Society. We want to help you develop full, coordinated programs in this field, and in preceptorships. We want to work with you and the hospitals in revitalizing and expanding internships and residencies.

Above all, we know you need money. We know it costs \$11,500 a year, on a national average, to put a student through medical school. We know you struggle just to stay above water . . . that you have turned to research grants out of need and even desperation . . . that costs throw a dark shadow over your future plans.

Well, the House of Delegates of our State Medical Society has called for subsidies to the medical schools, to be based on the number of students. Nor do we care from what state the student comes. In Pennsylvania—where no distinction is made—per-student subsidies have been a lifesaver to the medical schools and the growth of medical practice.

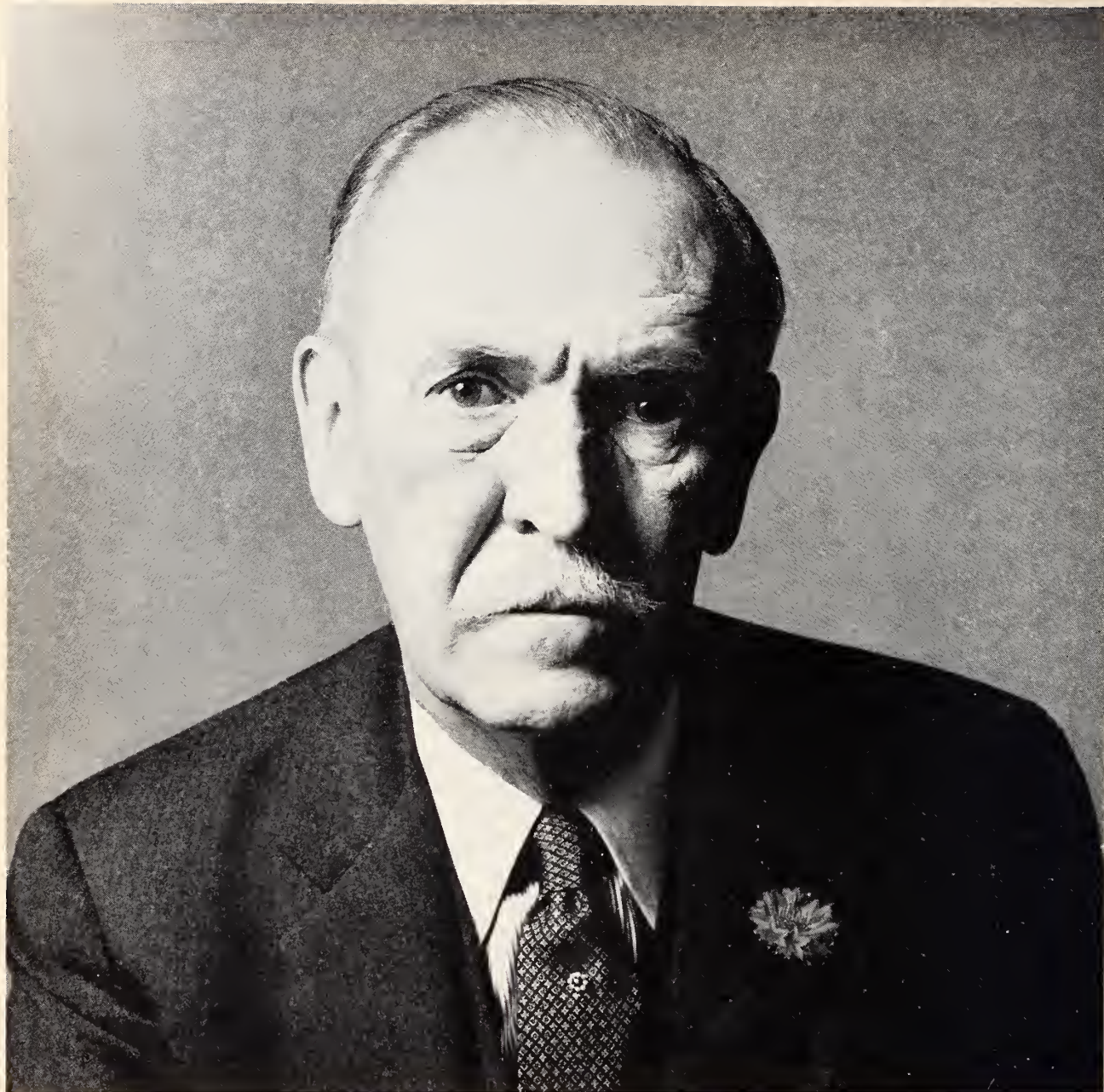
The higher the enrollment at a medical school, the greater the subsidy. This condition would encourage you—and the other schools—to boost your production of doctors.

A committee of our society is studying possible sources of revenue for subsidies. Of this much you can be sure—that our society, and our legislative staff, will strive in Springfield to give medical education the priorities it requires and deserves.

So fellow Illini, give your full measure of devotion to the health needs of our state. In turn, we of organized medicine will devote ourselves to you and your efforts.

Philip G. Thomson M.D.

Illinois is the nation's leading exporter with sales abroad amounting to more than \$2.5 billion per year. Illinois leads all states in the export of both agricultural and manufactured goods.



Help the Needy!

This patient may appear to “have everything” but, like so many people getting along in years, he may well be in need—*medically*. Though there is no evidence of organic disease, he does have symptoms (fatigue, vague aches and pains, malaise) that may be indicative of—

a need to maintain anabolic balance...to counteract declining gonadal hormone secretion and forestall premature degenerative changes related to estrogen deficiency;

a need for mood elevation...to impart a gentle emotional uplift;

a need for nutritional supplementation...to compensate for the poor eating habits and subsequent dietary insufficiency of so many older people.

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	Each MEDIATRIC® Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC® Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsic.	30.0 mg.	—
Ascorbic acid	100.0 mg.	—

Contains 15%
alcohol†
† Some Loss
Unavoidable.

Contraindication: Carcinoma of the prostate, due to methyltestosterone component.

Warning: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

Side Effects: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

Suggested Dosages: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

Supplied: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.

No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.



AYERST LABORATORIES
New York, N.Y. 10017 • Montreal, Canada

**ILLINOIS
MEDICAL
ASSISTANTS
ASSOCIATION
REPORT**



When I was a child and my mother took me to see our family doctor I thought that it must be fun to be the lady who came to the reception door, dressed in white and looking very pleasant and efficient to announce to my mother "The doctor will see you now."

I thought that this could be exciting to be the doctor's helper. The years have passed by and now I am a medical assistant and I realize that there is more to this job than meets the eye of an impressionable ten year old child.

It is still very important to be pleasant to the patients in the reception room; however, there are many more things you must do to be a good medical assistant. In fact it might be a good idea to keep a card file on information relative to your work for your co-workers to follow when it is impossible for you to be at the office.

Now you are going to say, "I have enough to do during the day without setting up a card file of my duties." It really isn't so hard to do if you will write some daily duties, give a few of them to your doctor and let him read them and initial them so you know he approves, and in this way he will know how you "keep office."

Setting up such a system will take some time but it will also eliminate misunderstandings. Here are just a few suggestions:

1. You will need a reference system for all supplies and equipment you use—its storage and extra supplies. A note of who services your equipment.
2. Keep a card on banking information—where to bank the office money and

the account numbers.

3. Make a note of your doctor's techniques in the examination and in the treatment rooms.
4. Special index categories should be provided about medication for a patient's refill of prescriptions.
5. If your doctor has arranged to have a certain associate cover emergencies and hospital patients in his absence, information concerning that associate, his office hours, his method of handling emergency situations, and his telephone numbers should be recorded.
6. Make a note of your own duties with a short explanation of each.
7. Make a note for someone to be sure that the reception room is kept in order, so that the patient will get a good impression of the inner office.
8. General information regarding office hours and how to handle the appointment book and the telephone call-backs.
9. As the day progresses, make notations for other index cards as you think of them as you perform your tasks. Jot them down and do not forget to make a permanent card for them.

These are just a few reference items necessary to make your system an indispensable part of your assistance to your doctor. This system will be invaluable to your doctor and your co-workers. Once the system is set up make certain that it is kept current. If items are not corrected and current the system loses its efficiency and effectiveness.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

Chicago Medical Costs Rise Less Than National Average

Cost of medical care in Chicago rose 5.9 per cent last year—0.3 of a per cent less than the national urban average, the U. S. Bureau of Labor Statistics reported. While higher than Chicago's overall cost-of-living increase of 4.3 per cent, the medical climb was exceeded by public transportation (13.2 per cent) and food-store fruits and vegetables (8.9 per cent). Chicago's medical figure includes hospitals and some 40 representative general practitioners and specialists, a BLS spokesman said. The national medical increase of 6.2 per cent was reported in a Chicago newspaper as 7.3 per cent—which actually was the hike for men's and boys' apparel.

Signed Agreements With IDPA Required for 1969 Payments

Newly required individual agreements were mailed by the Illinois Department of Public Aid last month to physicians treating public-aid cases, and were to be signed and returned in 10 days. Without an agreement on file, IDPA cannot pay the doctor for services performed since January 1. This restriction is embodied in recent amendments to the Social Security Act. Future MD participants in IDPA programs will be sent an agreement to sign after submitting their first bill. The agreement reflects modifications urged by ISMS committees and trustees, but contains usual-and-customary-fee explanations which ISMS regarded as superfluous.

Flu Brings More Trouble: Slower Pay- ments from IDPA

Chiefly because of the flu epidemic, physicians' bills submitted to IDPA swelled to 123,000 in the monthly period ending January 15—some 25,000 more than in previous fiscal months. Since this pile-up exceeded the schedule of the data-processing apparatus, the result was payment delays—which are easing.

ADC Examination Provisions Conform with State Law

Does the Aid to Dependent Children program pay for pre-school physical examinations? It does for youngsters entering kindergarten and the first, fifth and ninth grades. These are the grade levels at which such examinations are required by state law. The question about examination payments frequently is asked IDPA representatives at ISMS Workshops on Government Health Programs.

(Continued on page 314)

practice management **NEWS**

A Service of the Public Relations and Economics Division

Expert Tells How to Choose The 'Right' Collection Agency

BY MARIAN THIELE

Among the most frequently-asked questions by new physicians setting up practice is "How do you find a good collection agency? How do you know it's reliable? When do you turn an account over to an agency?" To answer these and other questions, the Division of Public Relations and Economics interviewed Robert W. Howard, President of Professional Management Associates, Inc., Oak Brook, Ill. Mr. Howard is a member of the Society of Professional Business Consultants and has been in the field of professional management for medical and dental offices since 1957.



Robert W. Howard

Mr. Howard, how does a physician find a reputable collection agency to handle his delinquent accounts?

If the physician is new to the community—or thinking of changing collection agencies—he should first seek recommendations from his colleagues and other business acquaintances. Once he has a line on a particular agency, he should find out if it holds membership in such organizations as: (1) Chamber of Commerce; (2) Associated Credit Bureaus of America, Inc.; (3) Better Business Bureau; (4) Medical-Dental-Hospital Bureaus of America, Inc.; (5) American Collectors Association; and (6) National Retail Credit Association.

Does membership in these organizations assure reliability?

It certainly helps. However, to make sure the particular agency is best suited to the physician's needs, he should investigate its ownership and financial responsibility . . . its collection methods . . . its correspondence to patients. He should ask the agency for names of other doctor-clients . . . and find out their attitude toward the agency. **Is it important for a physician to choose**

a collection agency that specializes in medical accounts?

Not necessarily. Many general collection agencies are just as effective as some specialty bureaus. However, it is important that the attitude of the bureau be oriented both toward the physician and toward the patients with whom they will deal.

What guidelines should a physician use in selecting a good agency?

Generally, the agency should:

1. Be ethical, accurate and completely honest.
2. Have adequate office facilities, preferably close enough to the physician to facilitate personal visits.
3. Be adequately staffed with knowledgeable personnel familiar with medical billing practices, insurance and compensation requirements.
4. Charge a percentage based only on the money collected. It should not charge for investigative work even when it fails to collect from the patient.
5. Allow the physician to make final decisions on all accounts. It should never

'Collection Timetable'

The AMA suggests the following "Collection Timetable" to establish a routine billing procedure:

- 1st Month—Send statement
- 2nd Month—Send statement
- 3rd Month—Send reminder note
- 4th Month—Send letter
- 5th Month—Notify patient that since he has ignored all communications, the account is being turned over to a collection agency.

take legal action against delinquent patients without the client's consent.

- 6. Make regular progress reports and prompt, accurate remittances.
- 7. Not require the physician to sign a contract that would restrict his ability to change agencies or maintain some control over collection procedures.
- 8. Willingly agree to adjust fees in hardship cases rather than boost its commission by a cold pursuit of the total bill.

Speaking of commission, Mr. Howard, what is the rate commonly charged by collection agencies?

There is quite a variance here. The acceptable range of charges is between 33 and 50 percent. That may sound high, but it costs a good agency about 37 cents to collect each dollar owed. Frankly, I would be suspect of any agency that charges much below that. It may use high-pressure tactics that are likely to chase away patients. **When is the best time to turn over an unpaid account?**

I would say five to six months should elapse since the first bill or last payment before a physician hands a patient's account to a collector. As a rule, that's how long it takes for the collection routine in a medical office to bring in 90 to 98 percent of the money due. After six months, there's little chance of collecting the balance without help from the collector. There

is one exception to this rule. If there is an indication that the patient has skipped and the doctor's office has no way of tracing his whereabouts, the account should be placed for collection immediately. The account could also be placed sooner if the physician's office staff is unable to locate the family or executor of a deceased patient's estate.

What percentage of a physician's total accounts should an agency be expected to collect?

That differs according to the community and the physician's practice. Usually a good agency is content to collect 35 percent, aims for 50 percent, and is surprised by more. Harsh tactics might raise the rate of recovery, but most physicians want nothing to do with them. Yet, often it's the doctor, rather than a collector, who demands the kind of methods that brand physicians as being too business-minded. Such doctors should realize that top medical collectors approach slow-paying patients in a way that encourages payment and also maintains some level of goodwill.

If an agency has received no response from a patient, when should it return the account to the physician?

The physician should give the collector at least six months . . . sometimes even up to a year. Agencies may need four or more weeks just to locate the patient and much longer than that to collect. The doctor should not push the bureau with frequent calls. The agency's representative should report to his client regularly to keep him posted on collection progress.

What kind of information helps the agency collect from the patient?

Most agencies require: (a) Patient's full name, occupation, telephone number, business and residential addresses; (b) Proper person to be billed and relationship to patient; (c) Full amount of bill and date of last entry on the account.

Mr. Howard, what can a collection serv-

(Continued on page 350)



Frank Pfeifer
ISMS Legal Counsel

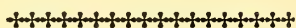
Advice from ISMS' Legal Counsel

To avoid involvement in any lawsuit brought by a patient against a collection agency, ISMS legal counsel Frank M. Pfeifer advises you to give the agency your account on an UNRESTRICTED basis. In that way it would be clear that you have no control over the manner in which the agency operates. For any legal action instituted by the agency, he warns you to require your specific authorization and your say in the selection of an attorney. Also, you should reserve the right to take the account from the agency at any time.

Socio-Economic News (Continued from page 311)

1968-69 President's Tour Will Finish in Effingham

Final Workshop on Government Health Programs of ISMS' 1968-69 year will be conducted Thursday, April 17, at Effingham, in connection with the President's Tour that day. The free Workshop—running from 1 to 5 p.m.—will review claims procedures involved in Medicaid, Medicare, general assistance, vocational rehabilitation, children & family services, and CHAMPUS (military dependents care). Physicians and medical assistants will attend. Seventh District doctors and their wives are invited to the 7 p.m. President's Dinner, preceded by a 1-hour reception. This will be addressed by Dr. Philip G. Thomsen, ISMS president, and State Rep. Leslie N. Jones of the 54th District. Both the Workshop and the Dinner will be at the Ramada Inn, junction of Interstate 70 and 57 and Illinois 32 and 33.



County Societies Can Hear Facts on Malpractice Plan

Leaders in the ISMS-sponsored Professional Liability (Malpractice) Insurance Program are visiting the counties to explain its benefits—and the reason why it was needed. Some 125 physicians last January heard a slide-illustrated presentation hosted by Peoria County Medical Society. Speakers included Dr. Fred Z. White, chairman of the ISMS Committee on Medical Economics and Insurance; Frank M. Pfeifer, ISMS legal counsel, and Donald A. Wahlstrom, vice president, Parker, Aleshire & Company, the program's administrators. Pfeifer reviewed moves to stabilize the malpractice legal climate in Illinois—a key objective of the insurance program. Other county societies wishing a malpractice presentation should get in touch with ISMS offices in Chicago or with Parker, Aleshire at 9933 Lawler Avenue, Skokie, Ill. 60076.

—by DON B. FREEMAN

YOUR ISMS INSURANCE QUESTIONS

QUESTION: *What types of medical practice are eligible for the Keogh tax-incentive retirement plan?*

ANSWER: Self-employed sole proprietors or partners can come under the ISMS-sponsored Keogh program. While medical corporations have been upheld by the courts and can use Keogh investment vehicles, the Internal Revenue Service still is challenging their status and their eligibility for tax advantages. Therefore ISMS members wishing to incorporate must file separate plan and trust agreements with IRS.

Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Ill. 60601. The column is a service of the ISMS Committee on Medical Economics and Insurance.

ILLINOIS MEDICAL JOURNAL

IN MEMORIAM.

Awards program this year was respectfully dedicated to the memory of WBBM-TV newsman Carter Davidson, right, here receiving winner's plaque last year from Dr. Philip G. Thomsen. Mr. Davidson's death late last year was mourned by all who respected the high ideals of journalism for which he stood. His memory, however—and his spirit of winning—live on at WBBM-TV, which was awarded another ISMS plaque at this year's ceremonies.



"For outstanding _____ of the year, we present the 1968 Medical Journalism award to . . ."

With that statement setting a tone of suspense and excitement, ISMS honored Illinois journalists for the fifth consecutive year at the Annual Medical Journalism Awards dinner, March 8, 1969, in Chicago's Ambassador West Hotel.

Amid pomp, splendor and the hushed excitement of over 200 guests, 12 media—selected from over 125 entries by a Publicity Club of Chicago judging panel—received the coveted winner's plaque for outstanding contributions in medical communications.

presenting . . .



THE
5th ANNUAL
ISMS
MEDICAL
JOURNALISM
AWARDS

"A tribute to the men and women who



For some award recipients, winning was a thrilling first-time event. For others, like six-time winner Arthur Snider, science editor for the **Chicago Daily News**, four-time winner Don Wooten, public service director of Rock Island's **WHBF-TV**, and three-time winner Bob Westerbeck of the **Rockford Register-Republic**, the award represented the latest in a long list of distinguished achievements in medical journalism.

The evening, hosted by the ISMS Board of Trustees, boasted two important "Firsts."

The **Chicago Tribune** became the first triple winner in the history of the awards program. Science writer Ronald Kotulak authored two of the Tribune's award-winning contributions—outstanding medical feature and best news story—while reporter Michael Smith contributed the year's outstanding medical series.

In addition, Station **WMAQ-TV**, Chicago, became the first double winner in two consecutive years with its outstanding documentary, "The Hidden Virus," produced by Joe Howard, and documentary series, "So Slow To Learn," produced by William Heitz.

The Danville Commercial News—a 1966 winner—was accorded "The Outstanding Feature of the Year" award among non-metropolitan newspapers for Reporter James Rick's revealing story on dizziness and its causes. Both Rick and Westerbeck are "graduates" of the ISMS Journalism Fellowship program.

"Big Picture" of Medicine

In addition to their journalistic excellence, the winning entries represented a wide cross-section of modern medicine's progress and problems.

Bob Stickler of the **Hinsdale Doings** described the life-saving techniques of a new cardiac care unit in his outstanding news feature . . . the plight of the mentally ill in Lake County received the attention of Larry Leonard in his discussion series on Radio **WKRS** . . . while the many problems, medical and ethical, surrounding heart transplants received in-depth coverage by Chicago Station **WBBM** as well as award winning stories by Effie Alley and Stanley Pieza of **Chicago's American** and Art Snider of the **Chicago Daily News**.



NEW FACES, FAMILIAR FACES—Chicago's American reporters Stanley Pieza and Effie Alley, top, express delight at being selected winners for first time. Six-time winner Art Snider of the **Chicago Daily News** and four-time winner Don Wooten, left, of **WHBF** Rock Island, flash smiles which show that winning is always a thrill, no matter how many times you do it.



ell medicine's story the way it is"

1968 AWARD WINNERS

Newspapers

CHICAGO TRIBUNE—Feature and News Story by Ronald Kotulak, Medical Series by Michael Smith

CHICAGO'S AMERICAN—News Analysis by Effie Alley and Stanley Pieza

CHICAGO DAILY NEWS—Feature Analysis by Arthur Snider

HINSDALE DOINGS—Feature by Bob Stickler

ROCKFORD REGISTER-REPUBLIC—Feature by Bob Westerbeck

DANVILLE COMMERCIAL NEWS—Feature by James Rick

ELGIN DAILY COURIER-NEWS—Series by John Kim

Radio

WBBM—Report written and produced by Michael Hirsh

WGN—Discussion Series produced by Bruce Dumont

WKRS RADIO—Discussion Program directed by Larry Leonard

Television

WMAQ-TV—Documentary produced by Joe Howard and Documentary Series produced by William Heitz

WBBM-TV—Short Subject Series written by Robert Osborn

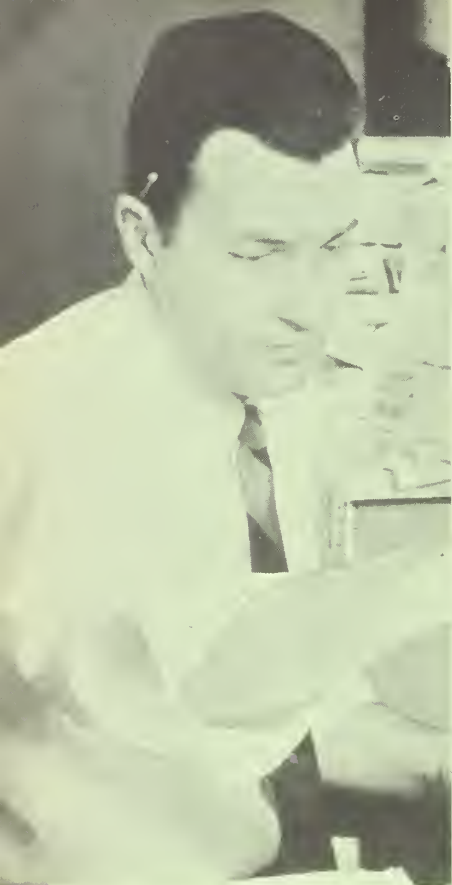
WHBF-TV—Documentary Series produced by Don Wooten



WINNING ENTRIES reflected ingenuity as well as broad understanding of medical problems. Case in point is reporter Ron Kotulak, far left, climbing fixture in surgical amphitheater to get better view of life-saving blue baby operation. His eye witness account won "Outstanding Feature of the Year" laurels for the Chicago Tribune.

HOSTS FOR THE EVENING and presenting the awards were ISMS President Dr. Philip G. Thomsen, left, and President-elect Dr. Edward W. Cannady, center. At right, program MC Dr. Matthew B. Eisele, PR Committee chairman, smiles broadly as he announces winner.





FIRST TRIPLE WINNER in Program's history was *The Chicago Tribune*. Science Writer Ronald Kotulak left, authored two of the Tribune's award-winning contributions, reporter Michael Smith, center, the third. WMAQ-TV producer William Heitz, right, picks up station's second award of the evening, making the Chicago station the Program's first double winner for two consecutive years.

Rock Island TV station **WHBF's** winning entry reviewed the controversial medical-legal problem of "The Criminal Chromosome," while the everyday problems of smoking, nervous tension and the "Pill" received attention by Chicago radio station WGN in its award-winning "Extension 720" series.

No subject was too technical—or controversial—for this year's winners. **WBBM-TV's** startling series "V.D.—A New Epidemic?" is one case in point, as is **WMAQ-TV's** suspenseful and heart-rending documentary on the dramatic new ways employed to help children who are slow learners.

Not only the scientific, but the socioeconomic aspect of medicine received attention from the award winners. Reporter John Kim of the **Elgin Daily Courier-News** explored the effect of the physician shortage in his community . . . while Michael Smith probed the exodus of

practicing physicians from Chicago with his award-winning series in **The Chicago Tribune**.

The program was not without its note of sadness. Conspicuously missing from the ranks of winners was **WBBM-TV's** Editorial Director, Carter Davidson, who died late in 1968.

To the memory of Mr. Davidson, who exemplified the highest ideals of journalism, the 1968 Medical Journalism Awards program was respectfully dedicated.

Summarizing medicine's tribute to the 1968 Medical Journalism awards winners, program MC Dr. Matthew B. Eisele, Chairman of the ISMS Public Relations Committee, said: "Your job has made our job easier by telling medicine's story to the public so accurately and comprehensively. Speaking for my colleagues, may I express the hope that the program has brought our profession and yours more closely together."

What's the most expensive Chicago hotel for sales meetings and conventions? You're wrong.

Most people figure that Chicago's fabled Hotels Ambassador has just got to be the most expensive hotel. For just about anything. And it figures.

After all, we are the home away from home for visiting show people and celebrities. And the home of the famed Pump Room and the almost as famous Buttery, Prince of Wales, Greenery and Royal Hunt.

And many of the largest corporations in the world do, in fact, hold their most successful sales meetings and conventions in the Hotels Ambassador.

But just because we're rich in tradition and decor and facilities and service

doesn't mean we're too rich for your blood.

What it means is that your company will get a lot more for its money at the Hotels Ambassador, without spending more money.

If you'd like to know exactly how much it will cost your company to hold a sales meeting or convention in Chicago's fabled Hotels Ambassador, fill-in and return the attached reply card.

We'll send you a free record album by Stanley Paul (he's the orchestra leader in the Pump Room) and while Stanley's giving you a song and a dance, we'll give you all the facts.



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J. R. Heimbaugh Jr., Vice President—Sales

Meeting Memos

March & April—Each Tuesday—State of Illinois Department of Public Health

Chest Conference
Chicago State Tuberculosis Sanitarium
1919 W. Taylor, Chicago

March 19-20—The Cleveland Clinic Educational Foundation

Postgraduate Course
2020 East 93rd St., Cleveland, Ohio
"Medical Microbiology"

March 21—Chicago Society of Medical History

First Annual Morris Fishbein Lecture
Quadrangle Club, University of Chicago, Chicago
"Historical Reflections on Longevity"

March 21-22—AMA Council on Rural Health

22nd National Conference on Rural Health
Marriott Hotel, Philadelphia, Pa.

March 22-23—American Psychiatric Association

8th Colloquium
Hilton Hotel, Pittsburgh, Pa.
"Postgraduate Training of Physicians in Psychiatry"

March 24-28—American Society of Anesthesiologists

19th Annual Postgraduate Course
Boston, Mass.
"Pulmonary Function"

March 28-29—AMA National Congress

The Socio-Economics of Health Care
Palmer House, Chicago

March 31-April 2—American Association for Thoracic Surgery

Fairmont Hotel, San Francisco, Calif.

April 1—St. Mary of Nazareth Hospital

General Medicine Lecture Series Program
1120 N. Leavitt St., Chicago
"The Sympathetic Nervous System"

April 8—St. Mary of Nazareth Hospital

General Medicine Lecture Series Program
1120 N. Leavitt St., Chicago
"The Blood Gases"

April 9-10—Illinois Public Health Association

29th Annual Meeting
Pick-Congress Hotel, Chicago

April 13-18—Johns Hopkins University

Health Services Research Seminar
Baltimore, Maryland

April 14-15—New York University Medical School

Postgraduate Course
550 First Avenue, New York City, N.Y.
"Cardiac Auscultation"

April 14-18—American Society of Anesthesiologists

Symposium on Clinical Anesthesia for General Practitioners
University of Oklahoma Medical Center
Oklahoma City, Okla.

April 15—St. Mary of Nazareth Hospital

General Medicine Lecture Series Program
1120 N. Leavitt St., Chicago
"Dialysis"

April 16-19—Chicago Committee on Trauma

American College of Surgeons
13th Annual Postgraduate Course
50 East Erie St., Chicago
"Fractures and Other Trauma"

April 17-22—American Dermatological Association

Marriott Camelback Inn, Scottsdale, Ariz.

April 18—Chicago Gynecological Society

Clinical Meeting
Evanston Hospital, 2650 Ridge Ave., Evanston

April 18-19—American Society of Anesthesiologists

4th Annual Inhalation Therapy Seminar
Sheraton Hotel, Philadelphia, Pa.

April 20-25—American College of Physicians

Conrad Hilton Hotel, Chicago

April 21-23—United For Health Care

39th Annual Meeting
Palmer House, Chicago
"Tri-State '69"

April 21-23—American Academy of Pediatrics

Annual Spring Session
Sheraton-Boston Hotel, Boston, Mass.

April 22—St. Mary of Nazareth Hospital

General Medicine Lecture Series Program
1120 N. Leavitt St., Chicago
"Bone Disorders in Renal Disease"

April 24-26—American Academy of Physical Medicine & Rehabilitation

Sheraton Chicago, Chicago

Marriage is neither heaven nor hell; it is simply purgatory.

—Abraham Lincoln

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Private Practice Physicians tried Magan on almost 700 patients whom they judged intolerant to aspirin and other salicylates.

The majority of these patients could take Magan and obtain the benefit of salicylate therapy.

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(magnesium salicylate, W-T)

May be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

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A single chemical entity . . . no coating, no buffering, sodium free and non-acetylated.

Composition: Each orange colored tablet contains 5 grains (approx. 325 mg) of magnesium salicylate.
Dosage: 1 or 2 tablets every 4 hours with a full glass of water.





Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



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NEW

PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

DUPLICATE SINGLE PRODUCTS

ATTENUVAX, LYOVAC Biological R
Manufacturer: Merck Sharp & Dohme

Nonproprietary Name: Measles virus vaccine, live, attenuated, (more attenuated Enders' line).

Indications: Immunization against measles.

Contraindications: Sensitivity to eggs, chicken or chicken feathers, neomycin, penicillin, or streptomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; patients with malignancies or those receiving therapy with corticosteroids, irradiation, alkylating agents or antimetabolites; gamma globulin deficiency; pregnancy.

Dosage: One vial (about 0.5 cc.), s.c.

Supplied: Vial, with diluent in disposable syringe—boxes of 1 and 10.

GENTRAN 40 Hospital Solution R

Manufacturer: Travenol Laboratories, Inc.

Nonproprietary Name: Dextran 40

Indications: Therapy of shock due to hemorrhage, trauma, burns, and surgery.

Contraindications: None mentioned.

Dosage: To be determined by physician.

Supplied: Solution—10% in saline and 10% in 5% dextrose, bottles of 500 cc.

INFLUENZA VIRUS

VACCINE, MONOVALENT Biological R

Manufacturer: Lederle Laboratories

Nonproprietary Name: Influenza virus vaccine, monovalent, Hong Kong strain.

Indications: Immunization against Hong Kong influenza.

Contraindications: Hypersensitivity to eggs or egg products.

Dosage: Adults & children over 10 years: 1 cc., s.c. Children 6 to 10 years: 0.5 cc., s.c. Children 3 months to 5 years: 0.1-0.2 cc., s.c. on two occasions, 1 to 2 weeks apart.

Supplied: Vials—4,000 CCA units/10cc.

INFLUENZA VIRUS

VACCINE, MONOVALENT Biological R

Manufacturer: National Drug Co.

Nonproprietary Name: Influenza virus vaccine, monovalent, Hong Kong strain.

Indications: Immunization against Hong Kong influenza.

(Continued on page 338)

Characteristic of many G.I. patients: intense prediagnostic anxiety

For the already anxious patient, diagnostic studies beyond the first examination—G.I. x-ray series, instrumentation, lab work-ups—can be highly stressful experiences, provoking additional anxiety at each preparatory step and actual procedure.

Adjunctive therapy with Librium (chlordiazepoxide HCl) can be extremely useful during this difficult period. Its dependable calming action promptly helps relieve anxiety and apprehension, reducing emotional overreaction to the procedures and to the suspense. Less tense, the patient is better able to accept and comply with your medical advice; his work and rest are less likely to be seriously disrupted by anxiety, and the original presenting symptoms may appear less menacing. Where an organic lesion exists, the antianxiety effect of Librium can help reduce emotionally induced exacerbation of symptoms.

If continuing antianxiety therapy is indicated after diagnosis, Librium, in proper maintenance dosage, is well suited for long-term use. And the drug can contribute significantly to the total management of your gastrointestinal patient.

Characteristic Librium effect: (chlordiazepoxide HCl)

- ☐ quickly relieves anxiety
- ☐ helps improve response in psychophysiological disorders
- ☐ seldom unduly impairs mental acuity or ability to function in proper maintenance dosage
- ☐ has wide margin of safety

for prediagnostic anxiety

Librium[®]

(chlordiazepoxide HCl)

5-mg, 10-mg, 25-mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.



Roche

LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

OBITUARIES

Dr. Paul J. Borrows, Antioch, died Aug. 18 at the age of 67.

Dr. W. G. Buckler, Bloomington, died Jan. 5 at the age of 77.

Dr. Oscar G. Carrera, Chicago, died Oct. 28 at the age of 69.

***Dr. V. M. Corman**, Rushville, died Dec. 27 at the age of 80. He was past president of the Schuyler County Medical Society and a member of ISMS Fifty-Year Club.

Dr. William T. Davis, Murphysboro, died Jan. 21 at the age of 87.

***Dr. Hugo O. Deuss**, Chicago, died Nov. 1 at the age of 67.

Dr. John W. Devereux, Honolulu, Hawaii, formerly on the faculty of Rush Medical College, died Oct. 14 at the age of 60.

***Dr. Alexander A. Goldsmith**, Glencoe, died Jan. 25 at the age of 90. He helped organize the Chicago Society for Internal Medicine, was treasurer for 40 years of the Chicago Pathological Society and was a member of ISMS Fifty-Year Club.

***Dr. Paul B. Hartley**, Jacksonville, died Jan. 5 at the age of 73. He was past presi-

dent and secretary of the Morgan County Medical Society and a member of ISMS Fifty-Year Club.

***Dr. Milton H. Kronenberg**, Peoria, died Jan. 12 at the age of 68. He was a fellow in the Industrial Medical Association, American College of Preventative Medicine and campaign director for the Peoria Chapter of the National Cystic Fibrosis Research Foundation.

Dr. Sidney Masel, Chicago, died Sept. 11 at the age of 50.

Dr. Nikola Mihalczic, Broadview, died Sept. 21 at the age of 44.

Dr. Margaret Rottschaefer, Lowell, Ind., a medical missionary in India for 47 years, died Jan. 22 at the age of 83. She lived for a time in Chicago.

Dr. George Ruby, Aurora, died Jan. 16 at the age of 76.

***Dr. Henry A. Szujewski**, Chicago, died Jan. 30 at the age of 52.

Dr. August Wendel, a Chicago physician for 43 years, died Jan. 20 at the age of 70.

*Indicates member of Illinois State Medical Society.

Film Reviews

"Drugs Against Cancer," two half-hour films produced by National Educational Television in collaboration with the Public Health Service's National Cancer Institute, NIH, describe the Institute's continuing efforts to improve the cure rate of cancer. Filmed in color, they have been shown as part of the NET "Spectrum" science series.

The first film, "The Search," describes ways in which the Cancer Institute identifies and develops materials with anti-cancer potential, tests them in animals, and evaluates and possibly improves their usefulness against human cancer. The second film, entitled "The Battle in the Cell," dramatizes research efforts to achieve selective toxicity with cancer drugs, illustrating the life cycles of normal and cancer cells and current research to determine optimum drug doses and schedules. The films may be obtained through the National Cancer Institute, NIH, Public Health Service, Department of HEW, Bethesda, Md. 20014.

"Light of Your Life," a 15-minute color film urging testing for glaucoma, is available from the International Film Bureau, Inc., 332 S. Michigan Ave., Chicago, 60604. The film demonstrates that glaucoma destroys vision by developing pressure within the eye which diminishes the field of view, and describes testing procedures available and remedial treatment.

Presented as a personalized experience of a factory foreman and his family, the film provides valuable information on general eye care and methods of protection under various circumstances. Content is comprehensive, informative and of value to professional and public groups interested in child care, health, nursing and teacher education, as well as workers in welfare agencies. The film was produced by the Illinois Society for the Prevention of Blindness. Requests for showings of this moderately priced film available for sale or rental should be addressed to the International Film Bureau.

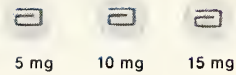
That's why Abbott's got what it takes— a pill and a program for each patient

THE PRODUCT—5 Different Strengths

For smooth appetite control plus mood elevation

Desoxyn® Gradumet®

Methamphetamine Hydrochloride in Long-Release Dose Form



For patients who can't take plain amphetamine

Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride, 60 mg. Sodium Pentobarbital



Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride, 90 mg. Sodium Pentobarbital



THE PROGRAM—3 Patient Booklets



Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. Food exchanges and a comprehensive list of foods, showing their calories, are also included.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

Compact new booklet features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

902110



Please see Brief Summary
on next page.

Ask Your Abbott Man
For Patient Supplies.

BRIEF SUMMARY

Desoxyn® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates, or in those with history of manifest or latent porphyria.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Because of its sodium pentobarbital content, use Desbutal with caution in patients receiving coumarin anticoagulants. Pentobarbital may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

902110



New Pharmaceutical Specialties

(Continued from page 330)

Contraindications: Hypersensitivity to eggs or chicken.

Dosage: Adults & children over 10 years: 1 cc., s.c. Children 6 to 10 years: 0.5 cc., s.c. Children 3 months to 6 years: 0.1-0.2 cc., s.c., on two occasions, 1 to 2 weeks apart.

Supplied: Vials—400 CCA units/cc.

INFLUENZA VIRUS

VACCINE, MONOVALENT Biological R

Manufacturer: Parke, Davis & Co.

Nonproprietary Name: Influenza virus vaccine, monovalent, Hong Kong strain.

Indications: Immunization against Hong Kong influenza.

Contraindications: Allergy to eggs, chicken feathers, or chicken dander. Acute respiratory disease or other active infection, presence of poliomyelitis epidemic.

Dosage: Adults & children over 10 years: 1 cc., i.m. Children 6 to 10 years: 0.5 cc., i.m.

Children 3 months to 6 years: 0.1-0.2 cc., i.m., on two occasions, 1 to 2 weeks apart.

Supplied: Vials—4,000 CCA units/10cc.

INFLUENZA VIRUS

VACCINE, MONOVALENT Biological R

Manufacturer: Wyeth Laboratories

Nonproprietary Name: Influenza virus vaccine, monovalent, Hong Kong strain.

Indications: Immunization against Hong Kong influenza.

Contraindications: Hypersensitivity to eggs, chicken, or chicken feathers.

Dosage: Adults & children over 10 years: 1 cc., s.c. Children 6 to 10 years: 0.5 cc., s.c. Children 3 months to 6 years: 0.1-0.2 cc., s.c. on two occasions, 1 to 2 weeks apart.

Supplied: Vials—400 CCA units/cc.

COMBINATION PRODUCTS

KIDDISAN Cold Preparation—General o-t-c

Manufacturer: S. F. Durst & Co.

Composition: Phenylephrine HCl 1.25 mg.

Chlorpheniramine maleate 0.5 mg.

Salicylamide 30 mg.

Ascorbic acid 30 mg.

Indications: Temporary relief of minor aches and pains, and symptoms due to the common cold and hay fever.

Contraindications: None mentioned.

Dosage: Children over 6 years: 1 tablet q.4h., do not exceed 4 tablets/24 hours.

Children under 6 years: as directed by physician.

Supplied: Tablets, chewable.

PALS Vitamin Combination o-t-c

Manufacturer: Mead Johnson

Composition: Vitamins A, B₁, B₂, B₆, B₁₂, C, D, niacinamide, pantothenic acid, folic acid (0.05 mg.)

Indications: Vitamin supplementation for children.

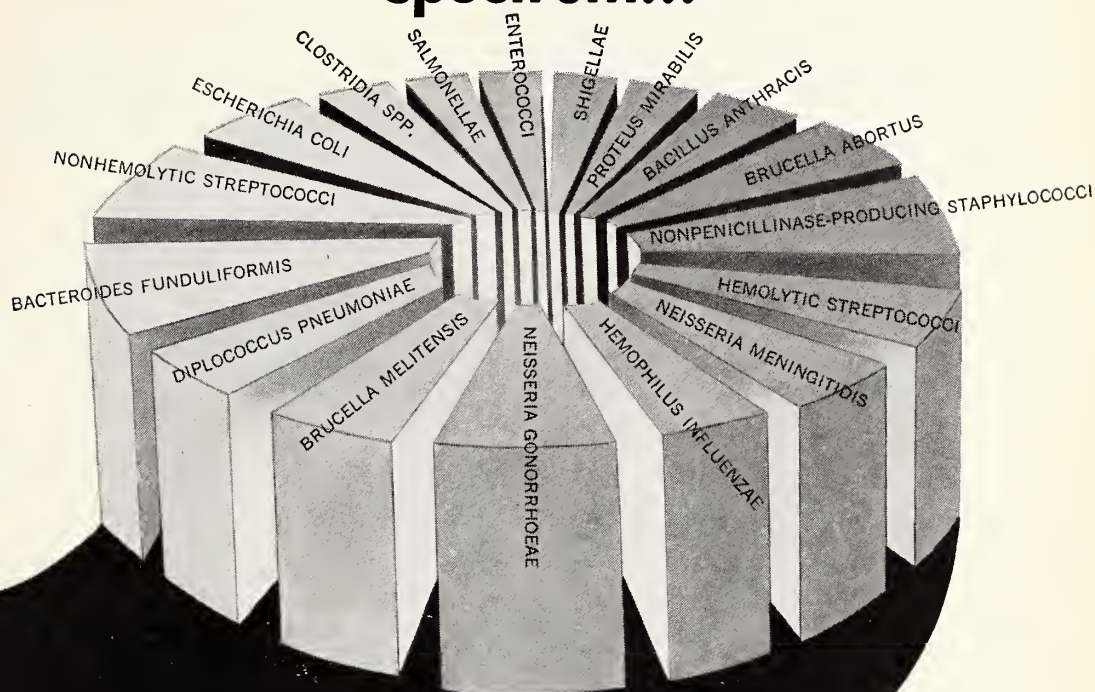
Contraindications: None mentioned.

Dosage: One tablet (animal-shaped) daily.

Supplied: Tablets, chewable—bottles of 21, 60, and 100.

Illinois is 4th among the 50 states in population and 3rd in personal income—though 24th in land area.

With the broad Polycillin (ampicillin trihydrate) spectrum...



...you have
a lot going for you
in the wide
range of bacterial
infections.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular.

Indications: Infections due to susceptible strains of Gram-negative bacteria (including *Shigellae*, *S. typhosa* and other *Salmonellae*, *E. coli*, *H. influenzae*, *P. mirabilis*, *N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and

monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site

and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

11-1/2/69

A.H.F.S. Category 8:12.16

Polycillin®
(ampicillin trihydrate)

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

BRISTOL

The penicillin you use like a broad-spectrum antibiotic

ANTISECRETORY SEDATIVE

Antrocol

Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to slow, even absorption.

Each Antrocol tablet or capsule contains 0.324 mg. of atropine sulfate, which is twenty-four thousandths of a milligram more than the smallest effective dose specified in U.S.P., Vol. 17. This slight increase in the smallest effective dose of the antisecretory factor (atropine) is all the average patient can tolerate without discomfort.

One Antrocol tablet or capsule taken three times daily lessens emotional stress and maintains a gastric function that is not conducive to the development of peptic ulcer.

Antrocol is also useful in the treatment of peptic ulcer. Dosage up to 8 tablets or capsules per day to obtain the desired antisecretory titer. When ulcer has healed, one Antrocol tablet or capsule morning and evening gives protection against recurrence.

Each tablet or capsule contains:

Atropine Sulfate	0.324 mg.
Phenobarbital (may be habit forming) ..	16 mg.
Bensulfoid, see white section P.D.R.	65 mg.

Side-effects: Toxic levels of atropine may produce flushing, dry mouth, blurred vision, tachycardia, or urinary retention. Precautions: Do not use in glaucoma. Use cautiously in prostatic hypertrophy.

Federal law prohibits dispensing without prescription.



WILLIAM P. POYNTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856

Antrocol®

ANTISECRETORY SEDATIVE

IDPA Payment Procedures

(Continued from page 271)

then payment of benefits goes to the recipient-patient who in turn is responsible for paying the physician.

Question: Have the physicians and other providers of medical services been informed that IDPA requires eligible recipients to assign their Medicare benefits?

Answer: All physicians and other providers of medical services have been so informed. If the assignment of benefits is not accepted by the provider of services, IDPA cannot figure in the payment for services.

Question: Are there other precautions to be taken?

Answer: The more pertinent factors have been covered. But it bears repeating that when billing the carrier for Medicare payments involving a public aid recipient, the case identification number of the recipient—copied verbatim from his current, green case identification card—must be entered in the space provided by question number five on the face of the billing form SSA 1490. Otherwise, the carrier will not provide IDPA with a copy of the benefits allowed. Also, the physician must supply IDPA a copy of the SSA 1490 sent to the carrier, and clearly marked duplicate. These are the main differences from billing on a Form MS 132. All previous discussion on the need for precision on all accounts holds true for processing an SSA 1490.

Patients Over 65 Receive 36 Minutes More Care Than Other Adults

Hospitalized patients 65 and over receive at least 36 minutes more of nursing care per patient per day than do other adults, a study by the American Hospital Association shows.

Hospitals—because of Medicare and Medicaid—have a particular interest in the relationship between age and the amount of nursing services received by patients. The first studies indicating that such a relationship does exist were made in 1965 in Los Angeles by the Commission for Administrative Services in Hospitals.

The AHA report pointed out that the difference in time “does not necessarily mean that care for the older group costs more per day, because the findings do not take into account the type of nursing personnel providing the care.”

Abstracts of Board Actions

(Continued from page 233)

ACUTE CARDIAC CARE STATEMENT APPROVED

The Council on Public Relations recommended Board approval of the Joint Statement on Acute Cardiac Care. The Board approved this statement, contingent on approval by the Illinois Nurses Association and the Illinois Hospital Association. The statement authorizes nurses, in the absence of a physician, to perform cardiac care on an emergency basis. Such may include monitoring, defibrillation, resuscitation, and the like.

NEW MEMBERSHIP BOOKLET DISTRIBUTED

Dr. Harwood reported on the publication of a new membership booklet, prepared under the direction of Dr. Henry Holle. This excellent brochure is available to all members who would like to interest others in association with ISMS. It is a succinct presentation of ISMS functions and services.

OSTEOPATHIC STATEMENT ADOPTED

The Committee to Study Osteopathic Problems reported, and after thorough discussion of all available information, the following resolution was adopted:

"Whereas Doctors of Osteopathy, qualified by education, now take the same exam as do physicians; and
Whereas these Doctors of Osteopathy, if they pass this exam, are then qualified to practice medicine and surgery in all of its branches in Illinois; and
Whereas the Bylaws of ISMS do not prohibit membership by a qualified and fully licensed Doctor of Osteopathy; and
Whereas the Federal Government recognizes qualified Doctors of Osteopathy; and
Whereas in recent action, the AMA suggests that each County and State Medical Society may accept qualified Doctors of Osteopathy as active members; now, therefore, be it
Resolved that an appropriate resolution to accomplish this be prepared and submitted for consideration to the next House of Delegates, with the question of membership eligibility to be determined on an individual basis at the local level."

Osteopaths are to be invited to attend the annual May ISMS Convention.

ESTABLISHMENT OF COUNTY HEALTH UNITS ENCOURAGED

Establishment and maintenance of county or multi-county Public Health Units, subject to voluntary action at the local level was encouraged by the Policy Committee. Dr. Franklin Yoder, director of the Illinois Department of Public Health, strongly urged the establishment and development of local Health Departments.

IDPA FORM AGREEMENT APPROVED

A modification of an agreement with IDPA which must be executed by every physician treating IDPA cases in order to effect reimbursement was approved. This agreement, while not as encompassing as the original, does meet Social Security and IDPA requirements. Forms will be sent to all physicians.

HOSPITAL EMERGENCY SERVICE PLANS

A proposed amendment to the Hospital Licensing Act on emergency service was reviewed. This amendment, proposed by the Department of Public Health, provides that community or areawide plans may be developed by hospitals to provide for combined emergency services in multi-hospital communities. The Department would adopt rules and regulations to administer these plans. The Board voted to support this legislation.

BOARD ENDORSES ANATOMICAL GIFT ACT

The Uniform Anatomical Gift Act, developed and endorsed by the American Bar Association and approved by AMA, designed to facilitate the donation and use of human tissue and organs for transplantation and other medical purposes, was discussed. The Board agreed that ISMS would support legislation in line with the Uniform Anatomical Gift Act and asked that legal counsel suggest any necessary changes in the proposed Act appropriate to Illinois law.

PHYSICIAN IMMUNITY WHEN TREATING MINORS

An Act in Relation to Treatment of Minors With Communicable Diseases has been reviewed by the Legislative Council. This Act provides immunity to physicians treating minors for communicable diseases without parental consent. It also allows the physician to choose to withhold information from the parent as to treatment. The Council's recommendation that the ISMS support this legislation sponsored by the Department of Public Health was approved.

SCHOOL HEALTH FORMS

Dr. Mary Zeldes, consultant physician with the Illinois Department of Public Health, discussed the School Health Examination Form in great detail. She stated that before these forms could be distributed they would need the approval of ISMS. In addition, she pointed out some variations which had been made from the previous forms. After in-depth discussion, the amended form was approved. Dr. Zeldes assured the Board that the developmental history will be at the discretion of the physician.

MERCK PRESENTS SPECIAL GRANT

The revision and reprinting of the ISMS Speakers' Bureau Roster was underwritten by a one-time special grant from Merck Sharp & Dohme. Mr. Joseph Head, north central region manager of Merck, briefly addressed the Board and presented a check for \$5,000.

SAMA SUMMER JOBS PROJECT

SAMA, reporting through the Council on Medical Education, has established a summer jobs program whereby medical school students may be retained by hospitals to work at the hospital. The intent is to broaden the horizon of the student and give practical experience. The ISMS, Illinois Hospital Association, and IAGP would share equally in the administrative expenses of the project, budgeted at \$2,200. The ISMS has been named fiscal agent. The program received the endorsement of the Board.

DUPAGE COUNTY RECEIVES PRECEPTORSHIP GRANT

The Preceptorship Program is moving ahead in DuPage County. The program has received a grant from the Family Practice Foundation of the American Academy of General Practice for approximately \$14,000. In addition, other funds may be made available. The success of the program is being emphasized and other schools are being encouraged to participate on an organized basis. These successes have prompted Macon County Medical Society to move toward establishment of a \$750 preceptor program.

RECOMMENDING FOOD ITEMS

Dr. Willard Scrivner expressed the view that Illinois physicians should abstain from prescription writing for the distribution of food products for certain categories of people. He felt that the term "prescription" might create problems for physicians. After much discussion, the Board recommended that physicians be given the privilege of recommending food items in the best interests of the patient for the maintenance of health and prevention of diseases, without giving a prescription.

PER STUDENT MEDICAL SCHOOL SUBSIDY

The Board, supporting the stand of the Council on Medical Education, authorized the Council on Legislation to foster legislation permitting a subsidy to private medical schools based on the total number of students, rather than on the number of students from the State of Illinois. Dr. Frank Jirka, Chairman of the Board, reported, "It is important to develop a united front to present to the legislature on across-the-board subsidies, which have been approved as the best means of providing quality education in medicine."

MEDICAL EDUCATION RESOLUTION PASSED

Regarding the subject of Medical Education and a resolution of the IAGP Board, the Council on Legislation recommended support of the resolution and the concept of establishing Departments of Family Practice and Community Health in Medical Schools. The Board agreed to support the resolution and agreed to support the principle with all the means at its command.

CLINICAL LABORATORY ACT REVISIONS SUGGESTED

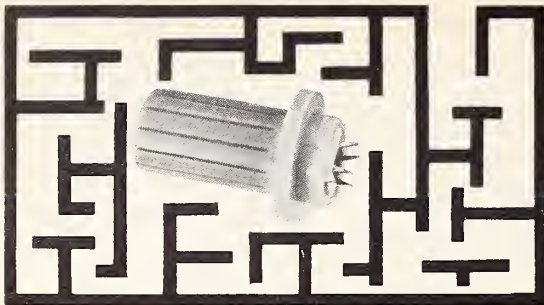
Dr. V. P. Siegel, reporting for the Legislative Council, recommended that the Board of Trustees support recommended revisions in the Clinical Laboratory Act. These would adopt the advertising restrictions of the Medical Practice Act, specify physician as one 'licensed to practice medicine in all its branches,' require that any Director of a new laboratory have a 'doctoral' degree rather than a master.

It was further recommended that the Blood Bank Act be amended to define plasmapheresis and require the presence of a physician during its performance.

The Board adopted a resolution backing these amendments.

Apron strings, heart strings, purse strings, harp strings.

—Howard Newton, a brief biography



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST

(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).



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ACCOUNTING, BOOKKEEPING AND TAX SERVICE

You can make your own time more profitable by devoting it to your business and letting us perform your routine bookkeeping and tax work on IBM computers.

At less than the cost of your time, we will furnish you the following:

1. Itemized monthly profit and loss statement with sales, cost of sales and expense breakdowns for the previous month and cumulative year.
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THE VIEW BOX

(Continued from page 272)

Diagnosis: This is an eventration of the hemidiaphragm. Films 2, 3, and 4 demonstrate elevation of the stomach and colon. What is unusual in this case is the marked elevation of the left kidney which causes a distinct density seen behind the left heart border on the PA chest film. Thoracic kidney as classically described is usually the result of a herniation through the pleural peritoneal hiatus. An IVP (film no. 4) which was done in conjunction with a pneumoperitoneum demonstrates the elevated eventrated hemidiaphragm noted immediately above the air shadow of the pneumoperitoneum. Eventration of the diaphragm is usually the result of a congenital lesion, however, it can be acquired following trauma to the phrenic nerve. The affected hemidiaphragm is usually represented by a thin aponeurotic membrane separating the lung from the abdominal contents. The left side is involved far more frequently than the right. Usually the stomach will be displaced in an upward direction with the fundus in a dependent position.

Predicting Sex of a Fetus

A method of predicting the sex of a fetus has been used with 100 per cent accuracy on a group of 63 pregnant women.

According to Dr. Anthony P. Amarose, Assistant Professor of Obstetrics and Gynecology at The Pritzker School of Medicine of The University of Chicago, the method involves taking fluid samples from the fetal water sac and examining the cells.

Amniocentesis or the removal of fluid was conducted at the Chicago Lying-in Hospital of The University of Chicago by Dr. Rajai M. Dajani and at the Albany Medical College, Albany, New York.

The first group of 31 predictions was based on a study completed two years ago. The second group of predictions on 32 Rh-sensitized pregnancies, including twins, was completed recently. This second group included 17 male and 15 female fetuses.

Dr. Amarose stated emphatically that "our preparations have never exhibited a sex chromatin mass in the cells from any sample with a predicted origin from a male fetus. Sex chromatin masses were seen only in those amniotic fluid samples scored as female in origin."



**public
affairs
library
reviews**

The Public Affairs Library is a new addition to the Illinois State Medical Society public affairs program. Each month in the JOURNAL, one or two books will be reviewed for physicians and their wives. The book topics will include politics, legislation, the Supreme Court, political parties, lobbying, and related governmental subjects. Books may be borrowed or purchased from ISMS. Write to Public Affairs Library, Illinois State Medical Society, 360 N. Michigan Avenue, Chicago, Illinois 60601.

THE OPINION MAKERS—THE WASHINGTON PRESS CORPS. William L. Rivers, Beacon 1967, \$1.95.

Since the 1960 election, and especially during the 1964 presidential campaigns, we have experienced the "power of the press" personally. That power cannot be over-emphasized. Modern political journalism elects and defeats a majority of candidates in today's legislatures.

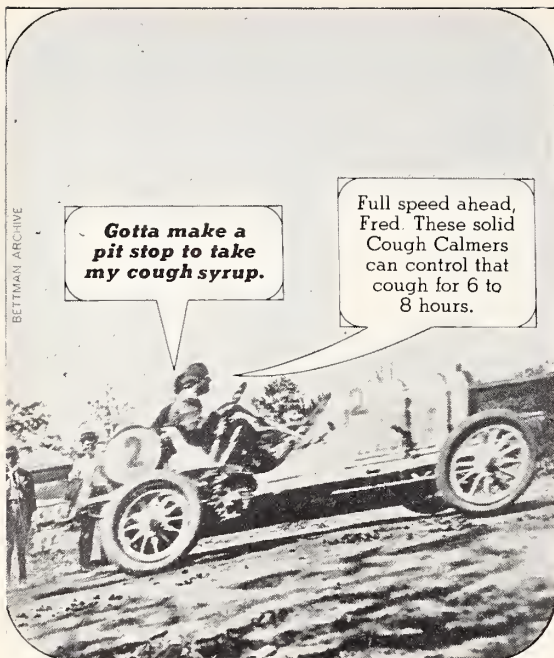
Author Rivers confronts the problem of security versus the "people's right to know." The job of the press corps is not to decide what is best, but instead, what is. He cites the example of the Bay of Pigs crisis. The press played an important role in Kennedy's image during and after the crisis period. At the time of the invasion in 1961 (just three months after JFK's inauguration) reporters were told at the height of the invasion that 5,000 patriotic refugees were penetrating Cuba. In fact, a force of 1,400 was involved. This was designed to mislead the enemy by misleading everyone.

In the chapter "Our Synthetic World," Rivers analyzes opinion, opinion leaders, and opinion source. Rivers maintains: "Our opinions on national affairs begin to take shape with the amalgam of information, opinion and innuendo which flows to us from Washington through the press corps—an amalgam at least in part by the predilections of the correspondents, their superiors, gov-

ernment officials, or all three. We are not abjectly at their mercy. Our acceptance, rejection, or reshaping is conditioned by the wild array of our own political and psychological learnings—which often means, whether we choose to believe "Newsweek" or "Time," the "New York Times" or the "Los Angeles Times," James Reston or David Lawrence, David Brinkley or Fulton Lewis, Jr. Although they usually agree upon what is happening in Washington, they are often at odds as to what it means!"

The Opinion Makers both praises and damns political journalism. It draws a picture of the huge corps of Washington correspondents and points out the influences—the elite of the corps, officialdom, bossdom—which shape the reports the American people hear, see, and read.

William Hogan, reviewing Opinion Makers in the San Francisco "Chronicle" stated: "the Government is so big that key officials, like the rest of us, are dependent on the press to know what goes on about them. Rivers shows how officials use reporters, as reporters use Government officials in an elaborate, baffling, highly complex newsmaking arena. This is one of the best behind-scenes reports on the practice and philosophy of newsgathering available."



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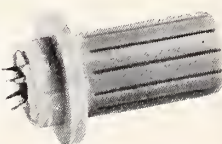
TB is still around.

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472-9

Practice Management Helps

(Continued from page 313)

ice do to speed up slow payment from Medicare, Medicaid, or any other government agency?

Nothing more than the physician himself can do within his normal billing and correspondence procedures. A collection agency can only write and make telephone calls; it has no special tactics for squeezing money from the government.

Do these bureaus offer any services other than collection?

Some agencies offer such additional services as accounts receivable billing and business management, telephone answering service, and employment service. Some provide pre-collection aids, such as a three-part form giving a last ten-day warning. **You call this a pre-collection service. In other words, the account hasn't been turned over yet, but the agency helps—**

Yes, that's right. If any payment is made to the physician before this 10-day period expires, then he retains the full amount. However, if the 10 days elapse without payment, the agency takes over the account automatically. The physician ceases all billings, and if he is contacted by the patient, refers him to the agency. If the doctor receives direct payment after the agency became involved, then it is entitled to its commission.

Do you have any further advice for physicians considering the use of a collection agency?

Yes. We have found that the best doctor-patient relationship results when the patient's account is kept current. If the patient falls behind in his financial responsibility to the physician, he begins to worry about the bill, hesitates to return for future treatment, becomes concerned about referring friends to the office and, in some cases, even starts speaking against the physician or his office. Many patients need to be disciplined in their financial responsibility for medical services and a good, reputable collection agency, familiar with the medical office, can play an important part in an orderly maintenance of this financial discipline. No physician who sets a fair and reasonable fee for his services, should feel guilty about turning his delinquent accounts over to a collection agency, after his office staff has made a reasonable attempt to collect the account.

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ESOPHAGEAL SURGERY, Three Days, March 27
ADVANCES IN SURGERY, One Week, April 28
ADVANCES IN ORTHOPEDICS, One Week, May 5
BASIC COURSE IN OBSTETRICS, One Week, April 14
BASIC COURSE IN GYNECOLOGY, One Week, April 21
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ULTRAVIOLET CYSTOSCOPY, 1½ Days, March 24
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Incision for Appendectomy

(Continued from page 288)

fect the uninvolved peritoneum. I should like to know more of your 'extra peritoneal' method. Of course, no abscess arising in the appendix can be opened without cutting peritoneum, a peritoneum forms the wall of the abscess. If you come to New York, I trust you will let me see you.

With kind regards,

Very truly yours,
(Signed) Charles McBurney

In recounting the historical background of the muscle-splitting incision for appendectomy, we have utilized all of the source material available to us.

On many occasions, as Interns at St. Luke's Hospital, on the McArthur service, we heard Lewis L. McArthur explain some of the details which have been documented.

Our conclusion is that the proper name for the gridiron incision should be the McArthur-McBurney Incision.

References

1. McArthur, Lewis L., "Choice of Incisions of Abdominal Wall, Especially for Appendicitis," *Chicago Medical Recorder*. 7, 289-292, Nov., 1894.
2. McBurney, Charles, "The Incision Made in the Abdominal Wall in Cases of Appendicitis, with a Description of a New Method of Operating," *Annals of Surgery*. 20:38-43, July-December, 1894.
3. Minutes of the November 1894 Meeting of the Chicago Medical Society—Junius Hoag, Secretary. Deposited at the Chicago Historical Society.
4. McArthur, Selim W., Editorial—"Landmarks in Surgery, The Muscle-splitting or Gridiron Incision for Appendectomy—An Historical Note." *Surg., Obs. & Gynec.* 65: 715-716, Nov., 1937.
5. Courtesy of John Crerar Library, Chicago.

Great economic and social forces flow with a tidal sweep over communities that are only half conscious of that which is befalling them. Wise statesmen are those who foresee what time is thus bringing, and endeavor to shape institutions and to mold men's thought and purpose in accordance with the change that is silently surrounding them.

—Life of Richard Cobden

The turning points of lives are not the great moments. The real crises are often concealed in occurrences so trivial in appearance that they pass unobserved.

—Ibid.

BLUE SHIELD REPORT



FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 222 NORTH DEARBORN AVENUE • CHICAGO, ILLINOIS 60601

Vol. 3, No. 4

April, 1969

Blue Shield's Usual And Customary Plan Grows

When the Illinois State Medical Society's House of Delegates adopted definitions of "Usual, Customary, and Reasonable" fees in 1966, Blue Shield responded by developing ways of applying the definitions to future Blue Shield certificates. In May 1967 Blue Shield obtained approval from the ISMS House to apply the Society's definitions to new Blue Shield accounts and to make payments to physicians on that basis.

Since August 1, 1967, when our first Blue Shield members chose protection under this method of payment, about 2,000 groups have been covered representing over 650,000 members. The Health Improvement Association was the largest single group in Illinois to enroll its members in our Usual and Customary program until January 1, 1969 when employees of the Federal Government were offered this broad protection. The plan is being offered to groups as small as four and we expect even greater growth in this particular area as time goes on.

More than a year after Illinois Blue Shield offered Usual and Customary programs, the National Association of Blue Shield Plans amended its membership standards to require each Plan to make available a program to pay physicians' Usual, Customary, and Reasonable charges.

Blue Shield payments to physicians on this basis take into consideration charge patterns for similar services provided under similar circumstances in the same geographic area.

Ongoing review and analysis of charge patterns provide the basis for revision.

Blue Shield's Usual and Customary program will not replace the indemnity programs which have characterized our Plan since its organization over twenty years ago, and which, despite shortcomings, have earned the endorsement and support of Illinois physicians.

When a physician is not paid in full under the Usual and Customary program, it is not because of an arbitrary decision but results from a demonstrable difference in the physician's fees from customary charge practices.

By definition the Usual and Customary program will pay for usual and customary care and will

make allowances for extra charges in unusual clinical circumstances when such circumstances are reported on our Physician's Service Report form.

Payments are geared to usual charges of physicians, both specialists and non-specialists.

An important purpose of the program is to reduce the number of partial payments based on fixed schedules of allowances and to eliminate patient insecurity arising from lack of predictability of medical care costs. By strengthening public confidence in the ability of the private sector to respond to changing conditions, we help to reduce the possibility of non-voluntary groups from influencing the practice of medicine and its financing.

Many professionals have asked the question, "Won't Usual and Customary coverage lead to fee schedules?". Only if the program is abused. For example, if Blue Shield failed to keep its data current then professional support in the program would be lost. Likewise, if physicians elevate their fees to seek maximum permissible payments, it would destroy the purpose of the program. Although there has been some evidence that charges were increased after our Usual and Customary program went into effect, our experience has shown that physicians have supported the concept and will preserve the integrity of the process.

The Illinois State Medical Society defines "Usual" as "that fee usually charged for a given service by an individual physician to his private patient—his own usual fee."

A fee is "Customary when it is within the range of 'Usual' fees charged by physicians of similar training and experience for the same service within the same specific and limited geographic area."

When the definitions of Usual and Customary are met, the term "Reasonable" may be applied.

Properly carried out with the understanding and continued cooperation of the medical profession, the Usual and Customary program will accomplish greater return for physicians from Blue Shield; a more appropriate share to physicians of the prepayment dollar; greater return to the public in benefits; and predictability of medical charges to the consumer.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

When Can Care To Patients In ECF's Be Covered By Medicare?

To determine promptly whether care furnished to patients in Extended Care Facilities is covered and can be paid under Medicare it is important to have the understanding and cooperation of physicians, staffs of hospitals, Extended Care Facilities, and of Utilization Review Committees.

Extended care is that covered level of care provided when the patient's condition upon discharge from a hospital requires that he be in an institution for the primary purpose of receiving continuous skilled nursing and other professional services.

Skilled services are those services that must be furnished or supervised by trained medical or paramedical personnel. A service is not skilled just because it is performed by a trained medical or paramedical person. For example, a service which can be safely and adequately self-administered or performed by a nonmedical person, without the direct supervision of trained medical or paramedical personnel, is a non-skilled service regardless of who actually provides the service.

Non-covered care is any level of care less intensive than extended care. Non-covered care was formerly referred to as "custodial care." This is care designed essentially to assist an individual to meet his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication which can usually be self-administered—and which does not entail or require the continuing attention of trained medical or paramedical personnel.

The attending physician customarily plans in advance for the needs of his patient including, when appropriate, transfer from a hospital into an Extended Care Facility. The hospital can and should assist in this planning process by transmitting to the facility a medical information summary prior to the time the patient is transferred which would include the physician's orders for the patient's care in the facility, a profile of the patient's condition, and the services expected to be needed.

Utilization review in ECF's: We have received many questions from physicians on specific ways Utilization Review Committees should carry out their responsibilities outlined in Social Security Administration instructions. For these reasons we have obtained some answers, explanations, and policy interpretations from the Social Security Administration.

When a Facility has no Medicare Patients: Utilization Review relates to admission and discharge policies, patient care practices, the quality and timing of professional services, and the functioning of the facility. At times some Extended Care Facili-

ties will have few Medicare patients, no Medicare patients, or patients who are no longer eligible for Medicare benefits. When this occurs, the question is asked "How frequently must the Utilization Review Committee meet?". Related to this question is also the question "How many participants must meet to perform the necessary utilization review?".

Although there is no rigid rule that a full Utilization Review Committee must meet weekly, the Committee must meet regularly to carry out sample reviews of admissions, durations of stay, and professional services furnished as long as there are beneficiaries in the facility regardless of their benefit status.

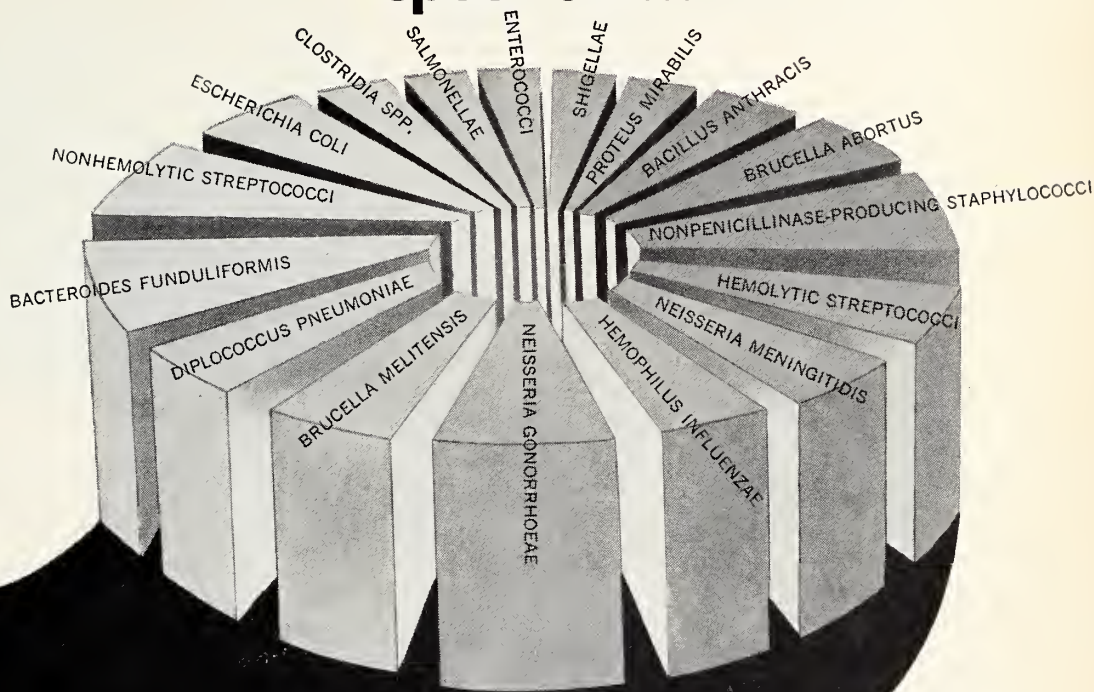
When the Utilization Review plan in an ECF limits review activities to Medicare beneficiaries and there are no inpatient beneficiaries, the Committee would not be required to meet until there were beneficiary cases to review. However, facilities that have experienced sporadic Medicare admissions should take steps to make sure that the Utilization Review Committee is informed when beneficiaries are admitted so reviews in all categories can be conducted and prevent required activities in any category from being overlooked.

When Entire Utilization Review Committee is Required: Although the term "Committee" is used by the Social Security Administration in most of its instructions and regulations on Utilization Review, it is not essential for the full Committee to meet whenever a Utilization Review issue arises. It is expected that reviews will be undertaken at intervals of 7 days or less because of the requirement for review of long stay cases within 7 days after they become extended duration. Although it is not necessary for the entire Committee to meet to carry out the consultation function, as one member could be assigned the responsibility of making various reviews, action by the full Committee or an ad hoc Committee consisting of at least two physicians is required when questionable cases are discovered. Ad hoc Committee decisions would be reviewed retrospectively by the full Committee at its next regular meeting. The full Committee could meet quarterly as long as the Department of Public Health is assured that this frequency is sufficient and that a subcommittee is functioning satisfactorily.

The full Utilization Review Committee need not meet to review level of care questions. One member can be asked to consider a case as needed to minimize time lapses and no consultation is necessary except when the facility requires medical consultation to evaluate the level of services needed in a given case.

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Indications: Infections due to susceptible strains of Gram-negative bacteria (including *Shigellae*, *S. typhosa* and other *Salmonellae*, *E. coli*, *H. influenzae*, *P. mirabilis*, *N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and

monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site

and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

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The president's page



Philip G. Thomsen, M.D.

A Chicago newspaper recently trumpeted the "news" that medical costs were the "biggest gainer" in the 1968 cost-of-living index, advancing 7.3 per cent.

This "news" alarmed me—for three reasons.

First, it was wrong. Medical costs went up 6.2 per cent, according to the government's official release. The item which went up 7.3 per cent was men's and boys' clothing. I cannot understand the confusion—unless the writer was thinking of hospital gowns!

My second cause of alarm was the enthusiasm with which we are attacked by instruments of public opinion. Because the physician is a *personal* and long-respected figure, he is a ready target for today's cynicism.

He's a much more convenient target than *impersonal* forces—such as hidden taxes, labor costs, and those vague, remote people who set the price of Scotch.

My third reason for alarm is that any marked increase in medical costs is troublesome. We physicians must take a responsible position on these costs—or else the Government will make them *its* responsibility.

What can we do?

Well, one thing we can do is extend the principles of Utilization Review—particularly since hospitalization accounts for more than one-third of the total health bill.

Not only should we reduce hospital stays of patients to the absolute minimum required for optimum care, we also should

avoid hospitalization entirely if adequate extended care facilities or home health-care services are available.

Excessive referrals—to inpatient facilities and Emergency Rooms—have been a chief contributor to rising health costs. Hospital daily service charges soared 165 per cent from 1950 to 1965—almost three times as much as physicians' fees.

We doctors must help reduce the over-use of Emergency Rooms, and I'm glad our Hospital Relations Committee is waging a campaign toward this end. ER cases have more than doubled at many Illinois hospitals over the past decade—hitting the pocketbook of both hospital and patient. A majority of these cases have been non-emergency.

So when patients telephone you, be sure to ask them to describe their condition in detail . . . try to determine if they truly need ER treatment. Avoid shunting patients to ER's simply because you're overworked, or because it's your day off or nighttime. Arrange for handling of your cases by another MD when you are unavailable.

We're aware, of course, that the hospitals—not just the physicians—must do something about hospital costs. So why not extend Utilization Review to the general operations of these institutions? This type of UR could stimulate fuller use of facilities, including a 7-day hospital week. It could encourage better bookkeeping procedures . . . joint purchasing of supplies . . . group laundry and catering services . . . other

(Continued on page 520)

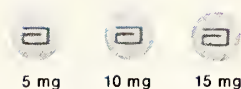
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Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. Food exchanges and a comprehensive list of foods, showing their calories, are also included.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

Compact new booklet features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

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10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates, or in those with history of manifest or latent porphyria.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Because of its sodium pentobarbital content, use Desbutal with caution in patients receiving coumarin anticoagulants. Pentobarbital may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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NEW

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SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

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New Dosage Forms: Of a previously introduced product.

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SULFAMYLON Cream Sulfonamide R

Manufacturer: Winthrop Laboratories

Nonproprietary Name: Mafenide acetate.

Indications: Adjunctive topical therapy of second- and third-degree burns.

Contraindications: None mentioned.

Dosage: Apply locally, once or twice daily.

Supplied: Cream—85mg. base/gm., tubes of 2 and 4 oz., jars of 1 lb.

TALWIN Tablets Analgesic-Non-narcotic R

Manufacturer: Winthrop Laboratories

Nonproprietary Name: Pentazocine HCl

Indications: Relief of acute or chronic pain, regardless of cause.

Contraindications: Increased intracranial pressure, head injury or pathologic brain conditions in which clouding of the sensorium is undesirable.

Dosage: Adults: 1 tab., q. 3-4h., may be increased to 2 tabs., p.r.n. Not recommended for children under 12 yrs.

Supplied: Tablets—50 mg. base, bottles of 100, 500, and 1,000.

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GAMULIN T Biological R

Manufacturer: Pitman-Moore

Nonproprietary Name: Tetanus Immune Globulin, Human.

Indications: Passive immunization against tetanus.

Contraindications: None mentioned.

Dosage: 250 units, i.m.

Supplied: Vials—250 units.

VIMPLEX-LF Vitamin Combination R

Manufacturer: Savage Laboratories, Inc.

Composition: Each cc. contains:

Thiamine HCl	10 mg.
Riboflavin (as phosphate sodium)	3.3 mg.
Pyridoxine HCl	1.7 mg.
Panthenol	1.7 mg.
Niacinamide	33.3 mg.
Cyanocobalamin	33.3 mg.
Sodium formaldehyde sulfoxylate	0.004%
Benzyl alcohol	1.5%

Indications: Vitamin B complex deficiencies.

Contraindications: Hypersensitivity to B complex fractions.

Dosage: 1 to 2 cc., i.m. or i.v., daily.

Supplied: Vials, with 30 cc. diluent.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

ibadubdub lubad

Anxiety is expected in the cardiovascular patient. A little may even be desirable.

But when anxiety is exaggerated . . . when it interferes with sleep . . . when it aggravates cardiovascular symptoms, your help may be needed.

Naturally, you'll want to reassure the patient.

And perhaps prescribe Equanil (meprobamate) as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently.

Almost 15 years' use has shown that Equanil is usually well tolerated as well as effective. Side effects are generally limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration. Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) 

See the Golden Pavilion on Your Orient Adventure

Leaving Chicago September 4 for Japan & Hong Kong



The Golden Pavilion floats delicately above its reflection in the lake, in Kyoto, the ancient capital of Japan. This is one of the unforgettable scenes to be encountered by members of the Illinois State Medical Society, their families and friends who leave Chicago September 4 on an Orient Adventure. From Tokyo they will have time to take a memorable trip to the "heart of Japan" via the Tokaido Line, Bullet Train, that displays the beautiful Japanese countryside at 120 miles per hour. On the Orient Adventure, private tours will be available exclusively for those members of the group who wish escorted sightseeing. Details available from ISMS Division of Educational & Scientific Services, 360 N. Michigan Ave., Chicago 60601.

ON THE COVER

The theme of the annual ISMS convention, to be held May 18 thru 21, is "Medicine in the 70's." Our cover reflects a conceptual view of the intersticing of medicine and the mode of the future.

Hopefully all members of ISMS will attempt to attend all or at least a portion of the sessions. It is at this annual meeting that the course of professional medicine in the state of Illinois is discussed and plans formulated for the concerted action of physicians. In addition there is significant opportunity for continuing education. And the Auxiliary meetings are most inspiring for the doctor's wife.

Chicago, the great metropolis on the shore of Lake Michigan, offers unique opportunities for the attendees to enhance their knowledge, relax, shop, and meet and greet friends, old and new. Plan to be a part of the scene.

New Dimensions in the Treatment of Alcoholism

BY ROBERT A. DeVITO, M.D., LAWRENCE A. FLAHERTY, M.D., AND
GERALD J. MOZDZIERZ, Ph.D./CHICAGO

Introduction

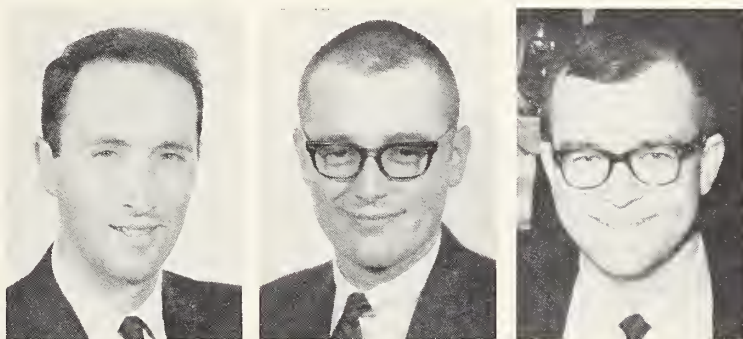
At this point in the twentieth century, alcoholism is an immensely complex national socio-economic and therapeutic problem. In its 1967 Manual on Alcoholism,¹ The American Medical Association noted that there are four to six million alcoholics in this country today, that 40% of all arrests in 1966 were for drunkenness, that the alcoholic employee loses 22 more days a year, suffers twice as many accidents a year and has a life expectancy of 12 years less than his non-alcoholic counterpart. Former Secretary of Health, Education, and Welfare, John D. Gardner² has observed that no other national health problem has been so seriously neglected, in terms of physicians declining to accept alcoholics as patients, hospitals refusing to admit alcoholics, and research programs receiving virtually no significant support

for investigation into the etiology and treatment of alcoholism. Only recently has there been a burgeoning professional and public recognition that alcoholism is an illness,¹⁻⁴ and one which confronts the potential therapist with a series of profoundly taxing challenges. The purpose of this paper is to describe the alcoholism treatment program currently in operation at the U.S.V.A. Hospital, Hines, Illinois and at the Loyola Outpatient Clinic, Madden Zone Center.

Treatment Philosophy and Program

The AMA Manual on Alcoholism has proposed that the etiology of alcoholism may lie in some complex interplay of physiological, psychological, and sociocultural factors, and that if a treatment program deals with only one of these areas, failure is practically inevitable. Yet, many alcoholic treatment programs concentrate on

Robert R. DeVito, M.D., (left) is assistant professor of psychiatry, Loyola University Stritch School of Medicine and attending psychiatrist to the Loyola-Hines Alcoholism Treatment-Research Program. **Lawrence A. Flaherty, M.D.,** is assistant clinical professor of psychiatry, Loyola University Stritch School of Medicine, director of the Alcoholism Treatment-Research Unit at Hines V.A. Hospital and a Diplomate of the American Board of Psychiatry and Neurology. **Gerald J. Mozdierz, Ph.D.,** (right) is an instructor in psychiatry at Loyola University Stritch School of Medicine and research director of the Alcoholism Treatment-Research Unit at Hines V.A. Hospital.



"drying out" the patient without followup psychotherapy. Others emphasize exploration of psychological and sociocultural determinants but discourage use of disulfiram (Antabuse), an established and useful biochemical treatment modality, according to many workers.^{1,5-6}

With these ideas in mind, the authors proposed a design for an alcoholic treatment program based on the fundamental hypothesis that alcoholism is an illness, specifically an addiction, in phases three and four of the Jellinekian System,³⁻⁴ with associated psychological and sociocultural determinants.¹⁻² As such, we adopted the view that there are two types of alcoholics, the excessive symptomatic drinker and the alcohol addict.⁴ The essential sign hall-marking the onset of the addiction process in the American alcoholic is thought to be "loss of control" as manifested by his inability to stop his alcohol intake after taking the first drink. It follows then that the establishment of firm consistent external controls would be the necessary first step in the rehabilitation of the non-toxic alcohol addict. The Loyola-Hines program attempts to implement this by requiring that a prospective candidate, usually a male alcohol addict well along in the process of detoxification (on a Hines medical or psychiatric ward), voluntarily sign a contract stipulating that he agrees to no privileges, no passes, and no visitors during his entire hospitalization on our treatment unit, the maximum stay being six weeks. The contract further requires a candidate to participate fully in the therapeutic program and offers him the opportunity to continue in outpatient treatment at either the Loyola Clinic, John J. Madden Zone Center, or the Hines Post-Hospital Care (PHC) Clinic.

While he is an inpatient on the Loyola-Hines unit, each candidate is exposed to a broad spectrum of treatment methods representing the etiological panorama of alcoholism: viz., (1) Antabuse drug groups and medically-oriented seminars outlining the Jellinekian phases of alcoholism (biochemical); (2) milieu, group, family and married couples therapy (psychological); and (3) A.A. meetings and manual arts therapy carried out in simulated industrial settings (sociocultural). In addition, the wives and families of alcoholics are invited to Al-

Anon meetings while alcoholics on other wards at Hines as well as outpatient graduates of our program are urged to attend a separate A.A. meeting held at Hines each week. Since alcoholics represent a wide variety of personality disorders, neuroses, and psychoses, the program implementers attempt to tailor treatment to the individual problem; e.g., the phobic alcoholic is encouraged to involve himself in individual outpatient psychotherapy following discharge while the man who drinks to escape from the responsibilities of married life is encouraged to attend married couples group therapy on both an inpatient and outpatient basis.

Of the various inpatient treatment approaches, the Antabuse-drug groups warrant particular attention. In these groups, the unit director introduces the alcoholics to the biochemistry of Antabuse in terms that they can understand. He indicates, for example, that mixing alcohol with this drug usually leads to extremely distressing physical and mental symptoms such as nausea, labored breathing, pounding sensations within the chest, and feelings of impending doom, because of a buildup of a toxic substance in the bloodstream, acetaldehyde. He then elicits the men's reactions to the seminar material with a view toward identifying each candidate's motivation concerning his treatment.

It has been our experience, thus far, that Antabuse, more than any other single treatment factor, stimulates such intense emotional responses as to expose an individual's real motivation in entering our program. To elaborate, some candidates absolutely reject the drug, claiming that it is a "crutch" and that they can "do it" on their own or that it is a health menace, capable of causing jaundice, blurred vision, and "bad" kidneys. Others, realizing that they are alcohol addicts, inclined to drink on impulse or for a variety of too easily specified reasons, accept the drug willingly. Still others accept the drug with reservations, knowing at some level that they will discontinue it at a later date—once they are "cured." These men never fully accept the fact that they are alcoholics and often take Antabuse to "please" the staff or other "authority" figures in their lives. The interactions among these three sets of men in a small group setting, have often been explosive and quite revealing.

Loyola

1. Group A: Psychotherapy Group (Senior author, 2nd year Loyola psychiatric resident, and senior elective Loyola medical student in psychiatry)
2. Group B: Married Couples Group (1st year Loyola psychiatric resident and Loyola social worker—supervised by senior author)
3. Group C: Married Couples Group (2nd year Loyola psychiatric resident and Loyola social worker—supervised by senior author)
4. Group D: Drug Group (Senior author)
5. Group E: Miscellaneous therapy or primary followup elsewhere (e.g., individual therapy, AA)
6. Group F: No formal followup therapy or AA intervention anywhere. Periodic communication effected via senior author or Hines social worker.

Hines

7. Group I: Drug Group (Unit ward physician and senior elective Loyola medical student in psychiatry)
8. Group J: No formal followup therapy or AA intervention anywhere. Periodic communication effected via Hines social worker.
9. Group K: Married Couples Group (Hines social worker and 2nd year Loyola psychiatric resident—projected)

The fabric of our inpatient treatment program is woven together by two key staff meetings held each week; (1) an admissions staffing conference, chaired by the unit director, during which a treatment plan is forged for each individual candidate; and (2) a discharge planning conference, conducted by the senior author, designed to provide every candidate with a smooth transition from an inpatient to an outpatient status. Thus far it has been demonstrated that a strong sense of continuity, as furnished by careful discharge planning and frequent outpatient feedback, is instrumental in maintaining high morale among both staff and patients.

Organizational Dynamics: Outpatient Phase

Our outpatient program is constructed in such a way as to attempt to maintain contact with every patient who is discharged from our inpatient treatment unit. To accomplish this, each man, upon discharge, is ticketed for at least one of nine groups at the Loyola and Hines outpatient clinics:

At the time of this report then, there are six "functioning" groups, and three research or miscellaneous groups (F and J for research, E for miscellaneous). Groups G and H (not listed) represent terminated cases at Loyola and Hines respectively.

Currently, the authors are scheduling a series of community field visits to local industrial firms in an effort to inform management about our services as well as to

obtain first-hand information from employers regarding their attitudes about and ability to readily recognize alcoholic employees. Similarly, community visits to Skid Row are being planned in order to assess the subterranean social dynamics allegedly in operation to maintain chronic alcoholism as a way of life.

Results

The following tabulations represent data collected through the *first nine months* of the program's operation.

A. Inpatient Data

1. Admissions = 159
2. Discharges = 129
 - a) Regular = 120 (93%)
 - b) Premature (ama) = 9 (7%)
3. Readmissions = 21 (17 different men)
 - a) % Readmissions = 16%
 - b) % Men readmitted = 13%
 - c) Average outpatient length of stay (1st 10 readmissions) = 14 days
 - d) Average outpatient length of stay (2nd 11 readmissions) = 72 days
4. Instances of drink-on the unit = 0
5. Elopements (All returned sober the same day) = 3
6. Average census = 27
7. Average length of stay = 36 days
8. Total number of different alcoholics = 142
9. Habitual excessive drinkers = 3 (2%)
10. Alcohol addicts = 139 (98%)

} by Jellinek
} criteria

B. Outpatient Data

1. Total population	= 112
2. Claiming total abstinence	= 75 (67%)
Average abstinence duration thus far	= 3 months
3. Currently sober	= 82 (73%)
4. Currently working	= 72 (64%)
5. Currently active in AA	= 60 (54%)
6. Currently taking Antabuse	= 55 (49%)
7. No data available	= 26 (23%)
8. Currently known to be drinking	= 2 (1%)
9. Known to have been hospitalized elsewhere	= 2 (1%)
10. Total who have been active in outpatient groups	= 58 (52%)

Discussion

There is much to comment on with regard to these data, but we will confine ourselves to three major areas. All readmissions to the program thus far have been alcohol addicts, two men having been readmitted twice (the program's limit). Of the 21 readmissions to date, 16 absolutely refused to take Antabuse, while four of the remaining five discontinued it shortly after becoming outpatients. This information supports our theory that most men who refuse Antabuse or accept it to please or "con" us, intend (consciously or unconsciously) to drink again. It is noteworthy, however, that our second 11 readmissions had a much longer average outpatient stay (72 days) than the first 10 (14 days) which in part was due to the fact that one of these men maintained his Antabuse for three months before discontinuing it.

Another interesting statistic is that only nine (7%) of our 129 discharges to date have been premature or against medical advice. Five of these nine, however, have occurred in men who had been readmitted. In all five cases, the stated motivation in leaving the program early was related to "fear of institutionalization." Suffice it to say that all five men began drinking again shortly after their second discharge, suggesting that not a "fear of" but rather a "desire for" institutionalization (dependency) may have been the more compelling motivation.

Lastly, the absence of drinking on the

unit is one of the brightest features of the program thus far and lends credence to the firm external control philosophy that underlies our treatment direction. In connection with this, many outpatients have remarked that the "No passes, no privileges, no visitors" rule has had a considerable impact on their lives in that it "forces" them to think about the consequences of their behavior, particularly on their families and employers.

Conclusion

In summation, even though the program's early results seem quite encouraging, the longstanding, multifaceted psychological problems of the alcoholic, when considered by themselves, militate against any immediate therapeutic optimism. In particular, the alcoholic's penchant for minimizing the extent of his problems as well as his tendency to avoid involvement and responsibility mark him as an extremely challenging individual to deal with on an outpatient basis. A heartening number of outpatients in our program, however, have at least accepted the fact that they are alcoholics and have begun to identify patterns of escape from stress within themselves that have antedated their dependence on alcohol as a tranquilizer or mood elevator. It is our surmise that the intensive inpatient experience serves as a catalyst in this process of painful self-appraisal. A longer time interval will be necessary nonetheless, to fully evaluate the efficacy of this program.

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New Alcoholism Treatment Program

The medical profession has been turning increased attention to the problem of alcoholism. Although the American Medical Association (together with almost all other health groups) has long recognized that alcoholism is a disease, it is only in the past few years that a greater degree of attention is being focused on the disease which affects six million Americans.

Throughout the state of Illinois increasing attention is also being paid to the treatment of alcoholism. One hospital which has long been involved in the treatment of alcoholism is Lutheran General Hospital, located in the Chicago suburb of Park Ridge. Lutheran General began admitting and treating alcoholics in 1960, the year it opened.

On March 7, the hospital opened its new 73-bed rehabilitation center which is devoted exclusively to the treatment of alcoholism. This will expand the hospital's current program which is now housed in a 38-bed unit within the hospital.

Heading the program is Nelson Bradley M.D., a psychiatrist, who serves as medical director for the center. Dr. Bradley is also a member of the American Medical Association's Council on Alcoholism. Serving as program director is Jean Rossi Ph.D., a clinical psychologist. Director of the center is the Rev. John Keller, Lutheran chaplain. Other full-time staff members include a Roman Catholic chaplain, a social worker, and counselors in addition to the nursing staff.

The treatment program is based on five major premises:

1. That alcoholism is an illness and requires treatment as such.
2. That the treatment should attempt to promote the health of the total person including physical, psychological, social and spiritual aspects.
3. That a short-term intensive concentration of treatment in the hospital is the best course for many alcoholics followed by continued help after leaving the hospital.
4. That the treatment is a two-level program with the first part directed at the alcoholism addiction and the second part at the social and emotional aspects of living.
5. That treatment is based upon present

conditions and that behavioural change is possible.

In most all cases, cost for treatment is covered by third-party insurance carriers. Blue Cross and Blue Shield of Illinois, for example, has covered alcoholism since the group's inception in the 1930's.

Once admitted to the treatment program, the patient is assigned a primary counselor whose function is to carry out the non-medical treatment as outlined by the center staff. All primary counselors work under the direction and supervision of the medical director and program director. There is a strong emphasis on informing the patient of the nature of alcoholism. This is done through a daily series of lectures, discussions and audio-visual presentations.

Daily group therapy sessions are conducted. The spouse and patient will be involved in lectures and group discussions which focus on alcoholism and marital relationships and dependency problems.

The patient is introduced to the program of Alcoholics Anonymous and is encouraged to participate in its meetings, both during his stay at the center and after his discharge. A.A. have long used the hospital's facilities for their group meetings.

Whenever possible, the spouse of the alcoholic (approximately 50% of the patients treated at Lutheran General are women) is encouraged to become involved in the treatment process. The spouse is involved in the weekly lecture and group session.

In the new center, a feature of the building is one floor devoted to apartments. This will permit the spouse in certain cases to live in the center and to actively participate in the total treatment program.

The goals of the program are basically these:

1. Abstinence. This is an essential condition for the person who has been addicted to alcoholism.
2. Behavioural change.
3. Promotion of interpersonal honesty and genuineness to gain acceptance and awareness of the needs of others.
4. Active involvement of the patient's family in the treatment process.

Following discharge, there is currently a ten-week series of therapy group discus-

(Continued on page 522)



THE VIEW BOX

By LEON LOVE, M.D.

*Director, Department of Diagnostic Radiology, Cook County Hospital,
and Clinical Professor of Radiology, Chicago Medical School*



Fig. 1

This 43 year old woman entered with a chief complaint of vomiting copiously for the past 24 hours. Physical examination revealed an acutely ill dehydrated patient. There was a succussion splash in the region of the left upper quadrant. The patient was given barium by mouth for further evaluation.

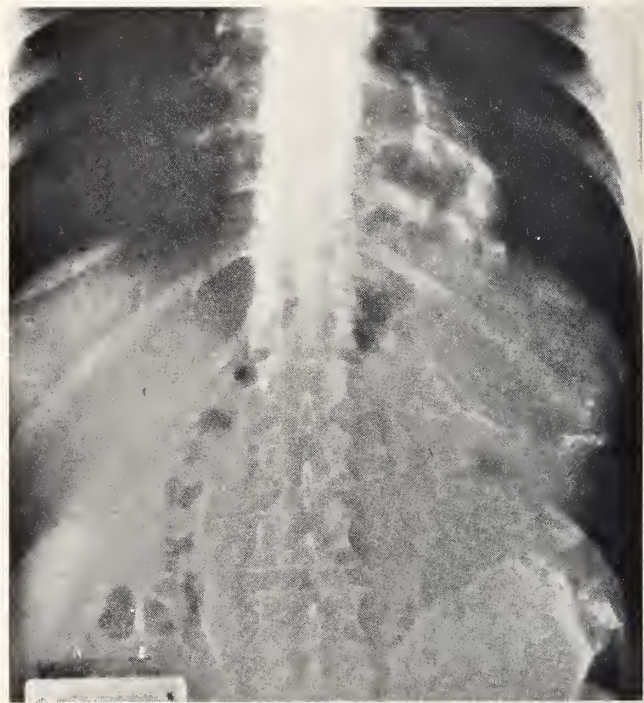
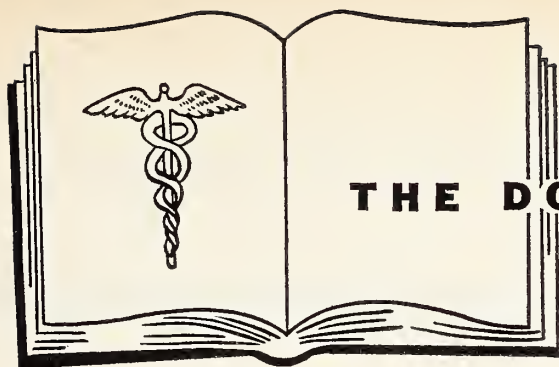


Fig. 2

What's your diagnosis?

1. Carcinoma of the stomach.
2. Obstructing pyloroduodenal ulcer.
3. Bezoar of the stomach.
4. Foramen of Morgagni hernia of the transverse colon.

(Answer on page 522)



THE DOCTOR'S LIBRARY

TUMORS OF THE LARGE BOWEL. Raymond J. Jackman and Oliver H. Beahrs. W. B. Saunders, 1968.

This useful, well presented and organized volume reflects the authors' vast experience in the clinical problems and management of the patient with tumors of the large bowel. It covers most of the current knowledge in 34 chapters divided into five sections. Excellent color plates of a variety of colorectal diseases cover the first section.

Small, medium sized, and large polyps and their malignant propensity are studied in individual chapters. Also, the authors review the clinical aspects and management of unusual polyps, such as Peutz Jegher syndrome, familial polyposis, villous tumors, among others. A wealth of material is included in malignant diseases of colon, rectum and anus. One of the authors (Jackman) presents his personal experience at the Mayo Clinic in the conservative management in selected cases of carcinoma of the lower bowel.

Numerous compilations of data, in tables and outline form, include both the authors' and others' experience. The references at the end of each chapter add to the value.

The material is presented in a concise manner, the illustrations are informative, and the book would be an excellent one not only for the proctologist, colon and rectal surgeon, but also for the general surgeon.

Gabriel Lorenzo, M.D.

THE LYDIA ROBERTS AWARD ESSAYS. Lydia J. Roberts American Dietetic Association, Chicago, \$4.00.

Fourteen award-winning articles (Lydia J. Roberts Essays) were collected and published in one volume to commemorate the 50th anniversary of the American Dietetic Association. The competition was named in honor of Dr. Roberts, a pioneer and

renowned nutritionist in the feeding of infants and children. These essays are mainly of historical merit and are arranged in four subject areas: Nutritional Deficiencies and Infant Feeding, Nutrition of Children, Nutrition Education, and the History of Nutrition and Dietetics. The latter includes changes in beliefs and attitudes, dietary standards, and food composition tables.

T. R. Van Dellen, M.D.

DEEP THROMBOPHLEBITIS-PATHOPHYSIOLOGY AND TREATMENT. J. Alex Haller Jr., M.D., Vol. VI in the series, Major Problems in Clinical Surgery, J. Englebert Dunphy, M.D., Consulting Editor, Illustrated, 130 pages, W. B. Saunders Company, Philadelphia, 1967.

Thrombophlebitis is a frequent diagnostic problem in almost every doctor's practice. Therefore, a monograph on deep thrombophlebitis should be of interest and value to students, house officers and practicing physicians.

Dr. Haller has outlined the pathophysiology, altered hemodynamics and therapy of phlebitis very well. Unfortunately, the subject material is not presented in sufficient detail to use the book as a reference source.

The section on the dynamics changes that produce the acute and chronic changes in the lower extremities following the onset of phlebitis is well done. It enables the reader to better gain an understanding of the underlying pathology and to treat it logically.

The chapters on the treatment of embolic complications emphasize the current controversy between the many available techniques for caval interruption. Again there is insufficient data to enable the reader to try and resolve this therapeutic problem. The section on venous throm-

(Continued on page 520)

Illinois Department Of Public Aid**Payment Procedures and Policies Explained**

HAROLD O. SWANK, DIRECTOR
ILLINOIS DEPARTMENT OF PUBLIC AID

Part VI of a Series.

In this sixth installment answers are given to a number of recurring questions asked by doctors in recent weeks—questions voiced in meetings attended by members of the Illinois Medical Society, questions telephoned or written to the Illinois Department of Public Aid in the course of regular business, and questions received as a result of request notices printed in conjunction with this series of articles.

Question: What does MA-NG mean?

Answer: MA-NG is an acronym—a shortened version of a long title brought about by using the first letter of the key words in the long title. MA means the case is Medical Assistance and the NG means No Grant. In other words, the recipient is eligible to receive only medical care or services as he or she has income and/or assets sufficient to meet regular living needs, but insufficient to meet medical payments.

MA-NG is one of several categories of assistance which the Department must administer as a separate entity.

Question: Are there other aeronyms in common usage?

Answer: Yes. The more frequently a long title is used the more need there is for a shortened version of it.

The corollary of MA-NG is MA-G, the latter meaning it is a grant case and hence also eligible for medical care. Other short titles include AABD meaning Assistance to the Aged, Blind or Disabled; ADC, Aid to Dependent Children; GA, General Assistance; AMI, Aid to the Medically Indigent, a local GA program; and others. Title XIX refers to the federal authority for Medical Assistance. Title XVIII is the federal authority for Medicare. IDPA is short for Illinois Department of Public Aid. CID refers to a recipient's Case Identification Card.

Acronyms are not confined to Public Aid. The medical profession has its AMA for American Medical Association; ISMS for Illinois State Medical Society; CPT for Current Procedural Terminology (the code book); Rx for drug prescription; and others.

Question: Should the doctor change the spelling of a name in his office file to conform with the spelling on the patient's case identification card?

Answer: Assuming the two names pertain to only one person, the doctor should use the name as spelled on the CID card. That way it matches the computer's profile of the case and forestalls reject of the bill.

A rule to remember is to consult the recipient's CID card each time a medical procedure is performed. Purposes are to make sure the CID has not expired and to copy the CID number and patient's name exactly as it appears on the card. Also needed is the date of birth of the patient.

It is not uncommon for a recipient to begin as a MA-NG case—medical only—but if illness continues, to then become a grant case (MA-G) either ADC or AABD. Should this happen the CID number is changed appropriately. Further, the case may revert back to MA-NG after the breadwinner recovers and resumes his job. Thus, it is mandatory that the current CID number be used or the computer can't match a bill with its stored profile.

Question: May a doctor use a stamped signature when billing IDPA on Form 132?

Answer: No. An actual signature in ink is required.

Question: Why is it necessary to indicate on the Form 132 the length of time a doctor assists in surgery?

Answer: Time is the major basis for paying the physician who assists the surgeon. Time refers only to actual time spent assisting in the surgical procedure and does not cover the entire period the assistant is away from his office, nor does it cover unavoidable delays waiting for assignment of an operation room.

Question: How are claims handled for allergy injections?

Answer: Some confusion certainly exists due in part to inadequacies in the CPT code. Each allergy procedure receives individual handling by a medically competent person on the IDPA staff before the bill is released to the computer. The reason is that sometimes an allergy bill is coded "test" when it is really an injection and vice versa. Also, when a test is being run, such as scratch tests in the 9300 CPT Code, the bill frequently does not say how many scratch tests were made. Similarly, in the case of injections, it is not always clear how many injections were made. So the doctor should indicate whether the procedure is a test or an injection, and how many. The usual, customary, and prevailing fee concept is allowed for the office visit charge to which is added the actual cost of the drug, if reasonable, plus 20 percent.

Question: A doctor sometimes encounters a patient who is old enough for Medicare but does not have a Medicare card. Both Continental Casualty (or Blue Shield as the case may be) and IDPA reject them. What should the doctor do?

Answer: This is largely a question of education. The Social Security Administration puts on an extensive information program in which the news media and other agencies urge eligible persons to sign up for Medicare, including Part B, or extended care. Persons who receive public aid are brought into Medicare as soon as they are eligible, to include Part B—the only facet in which Public Aid has a possible responsibility as an agency of second resource. If

HAVE YOU A QUESTION?

Physicians' questions concerning IDPA methods, procedures and policies are solicited and will be answered in these articles or by direct communication. The Department is desirous of eliminating misunderstandings and to work cooperatively with Illinois physicians. Send questions to:

IDPA Editor
Illinois State Medical Society
360 N. Michigan Avenue
Chicago, Illinois 60601

the patient isn't signed up for Medicare, the carrier pays no benefits, and IDPA has no responsibility under Part B of Medicare.

The doctor can readily tell if a recipient, age 65 or over, is covered by Medicare and Part B of Medicare by examining the CID number. If the first two digits are any of the following—01, 02, 03, 04, or 06—the patient has both coverages.

Question: Do dentists get full fees for all services?

Answer: Dentists, physicians, and podiatrists bill their usual, customary and reasonable fees. The Department of Public Aid pays either the usual and customary rate or the prevailing rate (if reasonable)—whichever is least.

Question: How should claims be processed when the patient's CID card has expired but claims he is still eligible for public assistance?

Answer: Assuming that the question refers to a Public Aid case and not to Medicare or General Assistance, the physician may check the patient's eligibility with the Department of Public Aid in the county of residence. It is unlikely that the case is eligible but still there is a remote possibility. If the case is General Assistance check with the local GA Unit.

Question: When IDPA issues a CID card, who has possession? The recipient or the caseworker?

Answer: A CID is issued directly to the recipient. That is why eligibility and all identifying data must be checked carefully. If the expiration date has passed the case is ineligible. If the card holder insists he is still eligible a call to the county Department of Public Aid is in order.

Question: If a doctor is overpaid how should he reimburse the IDPA?

Answer: If the over payment is the only procedure on the bill then simply return the check to IDPA with a brief explanation. If the payment covers procedures in addition to the overpaid item, cash the check and reimburse IDPA by personal check in the exact amount of the overpayment—along with a brief explanation. Do not debit a subsequent bill in the amount of the overpayment.

Question: Suppose a physician receives a recap which shows that a "bill is delayed in processing, do not re-bill" and subsequently gets a request from IDPA to re-bill. Which instruction should he follow?

Answer: This is not a common procedure but it can happen in the case of a very old bill, a lost bill, or perhaps a bill containing elements impossible to resolve during the normal "delayed in processing" period. If there is a request to re-bill, then please do so.

Question: What is the purpose of having the physician complete the Recap sheet?

Answer: There is no such requirement. The recap serves to show the physician which bills were paid at what charges and which bills, if any, are delayed in processing. The recap is an informational record for the doctor, not an operational document.

Question: An ADC family is also covered by a health insurance policy. How does the doctor bill for payment?

Answer: He should bill the insurance company first and then he may bill IDPA to see if any of the unpaid balance is allowable within public aid standards. The amount of the insurance benefits received should be entered in the space marked "Credits."

Question: Are payments allowed for physical examinations of school children?

Answer: Yes. Under Illinois law, children are required to take physical examinations

at four grade levels—entering kindergarten, and the first, fifth and ninth grades. IDPA pays for those examinations performed on ADC children. IDPA does not pay for Head Start entry examinations nor for Up-Ward Bound as these are funded under OEO projects, not IDPA.

Question: If a patient is in a foster home, which name is entered on the Form 132?

Answer: The CID is issued to the child, not the foster parent, although the latter's name appears as "in care of." When billing IDPA, use the CID number and the patient's name (the foster child) and his/her birth date.

Question: Suppose the doctor gets a payment recap and one procedure is marked, "delayed in reprocessing, do not re-bill." How soon will such bills be processed and after what interval should the doctor make inquiry if the bill remains unpaid?

Answer: Action on even very difficult bills resulting in either the payment or return of the bill to the doctor for clarification should not exceed 90 days. If without action within 90 days the doctor is requested to make inquiry of IDPA.

Question: Do the questions and inquiries of doctors fall into any particular patterns?

Answer: The aggregate of questions embrace almost all facets of medical procedures and the billing therefor. However, the bulk of the questions cluster into a half dozen areas. Many have to do with why precision is necessary in identifying the case, the patient, the eligibility, etc. Another very large proportion deals with the coding of medical procedures and the incompleteness of the CPT coding booklet. The meaning of usual, customary, reasonable and prevailing fees is never a dormant subject. Another area of marked interest has to do with medical procedures when the patient is an IDPA recipient and also covered by Medicare. It is to this latter group of questions that much of Installment Number Seven will be devoted.

Blood Lipoproteins May Be Key to Understanding Atherosclerosis

A better understanding of human atherosclerosis and perhaps of its control may come from the knowledge of the nature and function of blood lipoproteins, according to Dr. Angelo Scanu, Associate Professor of Medicine and Biochemistry at The University of Chicago.

"These blood components carry essentially all fats in the blood," Dr. Scanu said. These fats ordinarily are insoluble in water but, in a liquid environment such as circulating plasma, they dissolve because of their association with these specific lipoproteins.

Fats, cholesterol, and triglycerides have been implicated in the origin of atherosclerosis. Consequently, several attempts have been made to prevent or halt the progress of the disease by dietary manipulation or the use of drugs capable of interfering with the metabolism of these fats, Dr. Scanu continued. Although this avenue is still worth pursuing, important information is likely to come from the study of these blood lipoproteins.

"After all," said Dr. Scanu, "fats are only a part of these complexes and we ought to know how these complexes function as a whole."

Defines Nature of Protein Components

Dr. Scanu has long been interested in defining the nature of the protein components of the blood lipoprotein under the assumption that they serve an important structural and functional role. "Although the validity of such an assumption has been proven by studies from a number of other laboratories," he said, "the exact mechanism remains to be clarified."

A number of experiments both in humans and experimental animals have already provided convincing evidence that abnormalities in the handling of fats may be caused by either defective production or abnormalities of the protein carrier. "It is important, therefore," Dr. Scanu said, "to realize that abnormalities in fat metabolism may stem from substances other than fats, such as proteins and sugars." It has now been shown that the majority of disease states characterized by an accumulation of fats in the blood are due to im-

proper channeling of ingested sugars, and not of fats.

"There are other diseases where fats are low in the bloods. Even there the primary abnormality appears to reside in the proteins and not in the fats."

Necessary for Metabolism of Fats

Some time ago Dr. Scanu conducted experiments in dogs to demonstrate that integrity of blood lipoproteins is needed for the normal metabolism of fats. At intervals the animals were injected with a special detergent known to disrupt lipoproteins by pulling the fat from the protein. After a few months all animals had lost weight in spite of their large food consumption. They had evidence of malnutrition; fats had accumulated in the blood and various tissues without evidence of proper utilization. In addition, the large vessels of these animals contained large fatty streaks, which may be considered an initial step in atherosclerosis.

"It is conceivable," Dr. Scanu commented, "but far from proven, that atherosclerosis may be due to an imbalance among blood lipoproteins. Such a concept is not new; it was proposed a few years ago by investigators at the Donner Laboratory at the University of California at Berkeley." Dr. Scanu believes recent advances in the chemistry of lipoproteins have reopened the issue with better hope for success.

"If we can define a normal lipoprotein balance," he continued, "we should be able to screen normal from abnormal subjects and perhaps predict their proneness to atherosclerosis. This disease is difficult to diagnose before its complications, such as cerebrovascular accidents or coronary thromboses, have occurred."

Preventive Measures Unclear

According to Dr. Scanu, it is fundamental to make such a diagnosis early in order to be able to apply preventive measures.

"What these measures should be is not clear. We can tell the patients to stop smoking, stop drinking, live a calm life and reduce weight. However, when it comes to possibly correcting the imbalance in plasma lipoproteins which may lead to

atherosclerosis, we are presently in no position to offer a really effective help." This is still an unknown area where progress is expected only after the scientists define blood lipoproteins in rigorous physical, chemical, and biochemical terms.

"Such progress will not only be beneficial for our understanding of atherosclerosis," said Dr. Scanu, "but also of other di-

sease states characterized by abnormalities in fat metabolism."

Dr. Scanu is working to arrange an international meeting of lipoprotein specialists this Spring with the support of the American Heart Association. He is also editor and co-author of a book on lipoproteins to appear late this year.

Studies Virus Effects on Central Nervous System

A \$25,948 grant has been awarded by the National Multiple Sclerosis Society (NMSS) to Dr. Gordon Plummer, Loyola University, to investigate the relationship between the Herpes virus and diseases of the central nervous system. He is associate professor of microbiology at Loyola University Stritch School of Medicine.

Plummer, in common with other investigators, has been struck by the fact that the Herpes viruses have a marked tendency to invade the central nervous system. The outcome of this invasion is immediate when it takes the form of encephalomyelitis or paralysis. But many of these same viruses persist for years in various body tissues without causing any damage. Clinical results appear only when they are "activa-

ted" in a manner that is not yet understood.

It is likely that the viruses causing cold sores and chickenpox, for example, do not disappear from the body after the patient seemingly recovers. When suitably stimulated, the viruses become active again, causing familiar cold sore lesions in the one instance and shingles in the case of chickenpox virus.

Plummer will check on the activity of the various Herpes viruses in small laboratory animals to determine if the chronic infections they cause involve periods of complete latency or of slow multiplication that is not detectable by methods currently in use. He hopes to discover, too, whether certain types of the Herpes virus invade the nervous system more readily than others.

Renew Contract at Argonne

The U. S. Atomic Energy Commission (AEC) has renewed its contract with The University of Chicago for operation of the Argonne Cancer Research Hospital for five years at an estimated cost of \$21,000,000.

The University has had a contract with the Commission since 1950.

The Hospital, part of the University's medical complex, is a research institution devoted to study of radiation effects and use of radioactive materials in research. All research in the Hospital is unclassified and involves the use of nuclear energy for peaceful purposes.

Kenneth A. Dunbar, manager of AEC's Chicago Operations Office, who signed the contract, said: "The professional programs of the Argonne Cancer Research Hospital are of the highest caliber. Their work is regarded as a major contribution to medical research. With the renewal of this contract with The University of Chicago, we will enable them to continue their efficient

operation of the highly-regarded research center."

Dr. Alexander Gottschalk is Director of the Hospital and Associate Professor of Radiology in The Pritzker School of Medicine.

Studies currently in progress at the Hospital fall into three broad categories.

First, there is research into cancer treatment through high-energy radiation, including three powerful electronic devices: a 2,000,000 volt Van De Graaff X-ray generator, a specially-designed cobalt 60 therapy machine, and a 50,000,000 volt electron accelerator.

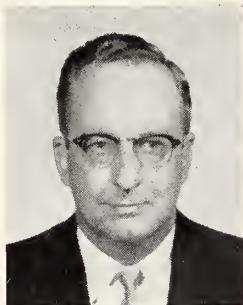
Second, there is research on the use of radioisotopes for treatment and early detection of cancer.

Third, there is research into the biological effects of radiation, performed through animal studies, and designed to broaden man's knowledge generally in this field.

Disease Of The Year

Swine Brucellosis

BY PAUL B. DOBY, D.V.M.; MILO L. JOHNSON, D.V.M.; ARTHUR L. STARKEY, D.V.M.; PAUL R. SCHNURRENBERGER, D.V.M., M.P.H.; AND
RUSSELL J. MARTIN, D.V.M., M.P.H./SPRINGFIELD



Paul B. Doby, D.V.M., (above left) is Superintendent of the Div. of Meat, Poultry and Livestock Inspection, Illinois Department of Agriculture, Springfield. Dr. Doby received both his B.S. and D.V.M. from Kansas State University. He is the past president of the Illinois State Veterinary Medical Association. Milo L. Johnson, D.V.M., (above right) is Head Veterinarian, Animal Health Div., U.S. Dept. of Agriculture, Springfield. Dr. Johnson received his B.S. and D.V.M. from Kansas State University. Russell J. Martin, D.V.M., M.P.H., (right) is a Regional Public Health Veterinarian, Illinois Dept. of Public Health. He is an assistant professor at the University of Illinois. Dr. Martin received his D.V.M. from Texas A. & M. University and his M.P.H. from the University of Michigan. Paul R. Schnurrenberger, D.V.M., M.P.H., is the Chief Public Health Veterinarian, Illinois Dept. of Public Health. He is also an associate professor at the University of Illinois Veterinary College and clinical assistant professor at the University of Missouri Medical School. Arthur L. Starkey, D.V.M. (not pictured) is a field diagnostician, Illinois Dept. of Agriculture, Div. of Meat, Poultry and Livestock Inspection, Springfield. He received his D.V.M. from Michigan State University.

The problems encountered with routine morbidity reporting programs are well recognized, but experiences during the 1964 viral encephalitis outbreak in Illinois suggested that possibly a brief concentrated period of surveillance on a specific disease entity might be a practical approach. A trial program, the "Disease of the Year" was organized along these lines by three agencies: The Illinois Department of Agriculture, the Illinois Department of Public Health, and the Animal Health Division of the U. S. Department of Agriculture. Brucellosis is a reportable disease in both man and animals in Illinois.

The project, conducted from July 1, 1966, to June 30, 1967, had three primary objectives: 1) to determine the prevalence of brucellosis in man and swine; 2) to study the epidemiology of the disease in infected swine herds, and 3) to increase awareness among the health professions and the general public.



To assist in accomplishing these objectives, the three sponsoring agencies enlisted the support of the various health organizations and agricultural groups in Illinois.

Prevalence in Man

In the period covered by this study, there were six reported human cases of brucellosis in the state. Two of these apparently were contracted outside of Illinois and therefore are not considered Illinois cases.

The first exogenous case was a 52 year-old female, ticket agent for a Chicago railroad, who had traveled in Great Britain during the summer and used fresh cream daily on her cereal throughout this trip. Her onset in September, 1966, was quite typical, characterized by fever, chills, night sweats, and fatigue. The organism isolated from the blood of this patient was typed as *Brucella abortus* 3. Types 1 and 2 are common, but 3 is quite rare in the United States. Type 3 is common in Great Britain, strongly suggesting the source was raw cream ingested while on vacation.

The other non-Illinois case was a 50 year-old Madison County resident, a butcher in a St. Louis grocery, with onset in April, 1967. It is probable that his source was occupational since he denied other animal contacts. An interesting side-note to this case is that the husband experienced orchitis during his illness. In July, 1967, shortly after his recovery, his spouse became ill with brucellosis. The two most probable sources for this woman were either venereal transmission or infection from preparing meat brought home by her husband. The latter seems unlikely in view of the infrequency of this source of infection in the general population at the present time. Because of the possibility of the unusual source of infection, her case is included in this discussion even though it occurred after the study period.

Table 1. Brucellosis Agglutination Rates In Various Occupational Groups In Illinois

Occupation	Number Tested	Number Reactive	Percent Reactive
General Population	946	0	0.0
Abattoir			
Pre-employment	506	4	0.8
Swine Producers	168	2	1.2
Abattoir Workers	551	71	12.9
Veterinarians	122	22	18.0

The only fatality encountered during this surveillance period was a Lake County cattle-buyer who died of pneumonia while ill with brucellosis. The exact source of his infection could not be determined, but he did have occupational contact with both cattle and swine.

The other three cases all had onsets in June, 1967, and all were adult males associated with packing plants slaughtering only swine. However, all three were employed in different plants, two in East St. Louis and one in Kankakee County. One was a superintendent, one straightened carcasses entering the dehairing machine, and the third carried carcasses in the plant. The clinical picture was typical of brucellosis in all three.

Serologic studies were conducted on five occupational groups in Illinois—general population, persons seeking employment in a newly-opened abattoir, swine producers, packing house employees and veterinarians (Table 1). Most of the general population sera had been submitted to the Peoria County Health Department for premarital or pre-natal tests. These were primarily urban residents and would be expected to have little livestock contact.

Very few of the pre-employment group were persons with abattoir experience but they would be expected to have more animal contact than the general public. Close clinical and serological surveillance will be maintained at this plant.

The swine producers were either members of the Illinois Pork Producers Association or were exhibitors at the Illinois State Fair. This suggests they are more progressive producers and should have above average swine herd health programs. Therefore, it is assumed that they would have less brucellosis in their herds than the average swine producer.

The packing plant employees were from two abattoirs. One plant had 21 employees, all serologically negative. At the other plant, 551 of the 783 employees were tested and 12.9% were found reactive.¹ When grouped according to work duties, the rate was 17% among the employees who had contact with warm beef but not with pork. In contrast, 40% of the persons with warm pork contact had *Brucella* titers. This strongly suggests that in this plant the swine presented a much greater brucellosis

hazard than the cattle.

Brucella reactions were found in the sera of 25% of the veterinarians in farm practice, general practice, and governmental employees in contrast to 5% of all other practice categories combined. It was not possible from the data to determine the relative danger from swine and cattle.

In general, it can be stated that human brucellosis in Illinois is presently an occupational disease involving swine contact.

Prevalence in Swine

The Illinois Department of Agriculture conducted a field test at the Peoria Stock Yards to determine the practicality of tattooing swine at market as a means of preserving herd identity for trace-back purposes. The tattoo was durable and readable after the hog was slaughtered and dehaired, but not prior to this time. This necessitates either a dual system of identification, or collecting the blood at some stage of processing after dehairing. The most likely source for the latter would be collecting heart blood after the hog has been eviscerated.

Both jugular and heart blood samples were collected from 391 swine and tested by the plate agglutination test. At the 1:25 dilution, 25 jugular and 4 heart samples were reactive. This lack of agreement demonstrates the need for further work to determine the relative merits of samples from the two sources.

Blood samples collected from 1,223 swine representing 147 herds were tested by the plate agglutination, BBA (Card), heat activation, acid plate antigen and rivanol tests. The plate and card tests are the approved standard serologic tests for the diagnosis of brucellosis in swine and cattle; the other three tests are supplemental tests used to confirm the standard tests and to assist in eliminating non-specific reactions. At the 1:50 dilution, the number of sera reactive to the tests varied from 0-13, illustrating the need for confirming serologic results with isolation of the organism, and for studies on swine of known *Brucella* status to improve our ability to interpret brucellosis serology in swine.

As part of a national survey, the Animal Health Division, USDA, collected 2,282 samples from 12 federally inspected

slaughter plants. Of these, 2.3% reacted at a 1:50 dilution on the plate agglutination test versus 0.2% on the card test.

As a result of the above, numerous changes were made in the testing procedures for swine brucellosis. In the future, all swine brucellosis tests in Illinois will be conducted only by state or state-federal laboratories, and three or more tests will be used on each serum sample submitted. The final appraisal of the test results will be made by a laboratory diagnostician.

When reactors are disclosed, a complete herd test of all breeding animals will be conducted at state expense; the herd will be quarantined, reactors will be identified permanently, and shipped for slaughter within 15 days. These changes plus the present requirement that all breeding swine be tested prior to sale, lease, loan or trade, should insure rapid progress toward eventual eradication of this disease.

Project Evaluation

The "Disease of the Year" project fulfilled two of its three objectives. It established the prevalence of brucellosis infection in man and swine in Illinois, demonstrating that the infection rate in high risk occupations is greater than would be expected from the low rate in swine. The awareness of the general public and the health professions was increased as evidenced by the interest expressed toward the eradication program. Because of the personnel shortage, it was not possible to study in depth the epidemiology of this disease on infected premises. This is regrettable since this type of information is extremely helpful in the eradication of the disease. Brucellosis will probably remain an occupational hazard to man until it has been eradicated from the animal population.

The "Disease of the Year" program was sufficiently successful to warrant repeating it in the near future on other diseases.

We would like to extend our gratitude to all the cooperating individuals and organizations for their assistance in this project.

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DOES BUERGER'S EXIST?

Did Leo Buerger¹ describe a new circulatory disease of young men in 1908? There is ample evidence that the condition bearing his name is indistinguishable from premature atherosclerosis, embolism, or arterial thrombosis. If so, the technical name Thromboangiitis obliterans (TAO) also is in error. In Buerger's day, the clinical aspects of arteriosclerosis were not well documented. His paper was published four years before John B. Herrick's classic treatise on the correlation of myocardial infarction and coronary thrombosis, secondary to arteriosclerosis.

Buerger² described a recurrent, progressive peripheral arterial insufficiency that involved the lower extremities more frequently than the arms; the final stage often ending in gangrene. Most of the victims were young Jewish males who were smokers. Superficial and deep phlebitis was often seen and there was no roentgenologic evidence of peripheral arterial calcification. Buerger admitted that clinically the disease could not be distinguished from arteriosclerosis; the difference being noted mainly in pathological specimens, indicating that TAO more closely resembled an inflammatory disturbance.

Diagnoses of thromboangiitis obliterans have been made for more than 60 years, yet many articles have been written questioning its existence. Textbooks still include the condition but the reader gets the impression that there is some doubt as to

whether or not Buerger's is a separate entity. Surprisingly enough, arteriosclerosis often is found in the amputated limb of a person with a preoperative diagnosis of TAO. Vocal skeptics on the subject are critical of Buerger's interpretation of the few published photomicrographs of the lesions. Wessler et al³ believed that in only two of the 42 amputated legs examined by Buerger was it possible to detect inflammatory lesions. In addition necropsies were reported in only three of these 42 cases. The acute phlebitic lesions that were reported are seen in a variety of unrelated conditions.

Wessler, in his critical report, mentions 84 patients who had the onset of arterial insufficiency before the age of 45. An additional 66 lower limbs were obtained from patients, considerably older, who had atherosclerotic gangrene. No one in either group had lesions resembling the acute specific histologic picture as described by Buerger.

DeBakey⁴ also was impressed by the frequency with which arteriography showed occlusive lesions in the more proximal arterial bed; and these lesions were consistent with atherosclerosis.

According to Darling⁵ "The young male smoker with advanced progressive arterial occlusive disease is clinically familiar, and the pathological study of the involved vessels, usually at the time of amputation, generally reveals advanced atherosclerotic occlusive disease." In 47 patients between the

ages of 16 and 37, he found that 32 (68 per cent) also had involvement of the proximal large vessels. Histologic studies revealed findings of atherosclerosis in 13 of 21 specimens obtained. We assume that he refers to patients who fall into the category of having Buerger's disease.

It is surprising also that no examination has ever revealed the nature of the etiologic agent. Tobacco, a common denominator in practically all cases, is known to have a vasoconstrictive effect on the vessels. But why does TAO single out young males and not affect females or older men? The few women with Buerger's disease were smokers and some were mannish in appearance. The fact that females are spared suggests a causal relationship to hormones, which are known to play a role in atherosclerosis prior to the age of 50. Harkavy's⁶ work on the allergic aspects of tobacco has never gained full acceptance.

Ergot was also blamed by Buerger but this was understandable because most of his patients were Polish or Russian Jews who consumed black rye bread. The fact that most of his patients were Jewish merely reflects his private and clinic practice. At the Mayo Clinic, I understand that many with TAO are of Scandinavian ancestry. Fungus infections also have been implicated but fungi are found frequently in tissues weakened by poor circulation.

The evidence suggests that many young males with a diagnosis of thromboangiitis obliterans have, in reality, early and severe atherosclerosis. Young men with no evidence of peripheral vascular disease frequently die of a heart attack. Early coronary arteriosclerosis usually is blamed. Cor-

onary thrombosis is a common cause of death in thromboangiitis obliterans yet these young adults are said to have Buerger's disease despite evidence of coronary arteriosclerosis.

But this does not mean that an inflammatory form of arteritis does not exist. The pathology of thromboangiitis obliterans as described by many is not specific and crosses into many forms of angiitis. During the past few decades numerous observers have recorded vascular phenomena associated with allergic reactions to the sulfonamides, serums, and respiratory infections. Apparently a number of syndromes are characterized by arterial inflammatory lesions. Oddly enough, males predominate with a ratio of 3:1. The peak age incidence is between 20 and 50 years.

T. R. Van Dellen, M.D.

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2. Leo Buerger, *The Circulatory Disturbances of the Extremities*. W. B. Saunders Company (Philadelphia & London), 1924.
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Dust Thou Art, But Mostly Water—\$3.50 Worth of Chemicals

The approximate value of all chemicals in the average adult human body is \$3.50, according to Donald T. Forman, assistant professor of biochemistry in the Northwestern University Medical School and head of the chemical laboratory at Northwestern-affiliated Evanston Hospital.

This represents a 257 percent increase over the same chemicals' estimated Depression-era value of 98 cents in 1936, Forman said.

In percentage terms, he said the adult body is composed of:

- Oxygen, 65 percent.
- Carbon, 18 percent
- Hydrogen, 10 percent
- Nitrogen, 3 percent
- Calcium, 1½ percent.
- Phosphorus, 1 percent.
- Other elements, including traces of gold and silver, 1½ percent.



Membership Forum

February 13, 1969

Dear Dr. Van Dellen:

I am writing in reference to the article entitled—"Two Year Experience with Electro-Convulsive Therapy in a Semi-Rural Hospital"—by the authors Frank, Frank and Johnson. This article is found on pages 37 to 39 in the January, 1969 issue of the *Illinois Medical Journal*.

On page 38 under "Methods of Treatment and Procedures," item three states "Patients are given 10 to 20 cc. of 5% Pentothal I.V., with a 0.5 to 1 cc. of a muscle relaxant (Anectine), which produced a light anaesthesia." I am certain that the authors meant to say that patients were given one or two cc. of a 5 per cent mixture or perhaps they meant that the patient was given 10 to 20 cc. of a 0.5 per cent Pentothal solution.

According to the statement in the *Journal*, these patients would have been administered anywhere between 500 and 1,000 mg. of Pentothal; this is at least five and perhaps ten times greater a dose than is customarily employed in this procedure. This is not to say that in rare circumstances such a dose might not be required, but it is important to find out the accuracy of the statement.

Sincerely,
John W. Ditzler, M.D.
Associate Director
Department of Anesthesia
Chicago Wesley Memorial Hospital

(Ed. note: In response to the inquiry of Dr. Ditzler, the author of the questioned item replies as follows.)

Feb. 24, 1969

We are extremely grateful to Dr. J. W. Ditzler for his careful reading of our article, "Two Year Experience, etc." and picking up a gross error in the recommended percentage of a drug used in the procedure as reported.

Dr. Ditzler is correct: patients are given 10 to 20 cc. of a 0.5% Pentothal solution. (The difference in the amount used is dependent upon the degree of apprehension of the patient.)

It is our sincere hope that anyone who might be influenced by this article will be made aware, through the columns of the *Journal*, of this error.

With sincere thanks,
Irving Frank, M.D., Ed.D.

Gentlemen:

Very briefly I would like to express my unhappiness with the circus atmosphere that has surrounded our cardiac transplant cases. In my opinion the Medical Society should discuss this phenomenon and hopefully—to me—take steps to remove this procedure from our T.V. screens and other news media to the hospital amphitheatre and medical journal. Medicine is not being practiced to entertain people, but to aid people.

Very truly yours,
Michael E. Carroll, M.D.
Chicago

18 February 1969

To The Editor:

There seems to be considerable confusion among the civilian medical profession as to where and how to bill the Army for services rendered to military personnel.

We believe the notice printed below would help your readers and relieve their frustration by giving them a definite guideline for collection of their fees.

Sincerely,
Joseph Israeloff
Chief, Technical Liaison Office
Office of the Surgeon General

How To Get Paid For Treating Military Patients

Payment to civilian sources for emergency professional services rendered to military personnel who are on active duty (as contrasted to retired, or inactive members of the National Guard or Reserve) is the responsibility of the Surgeon of the geographical area in which such services are provided. Collection cannot be made from the Office for the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), Denver, Colo., or its fiscal agents, who are responsible only for the payment of medical care rendered to authorized dependents and retired military personnel.

When a patient is identified as an Army member, on active duty, notification should be made immediately by telephone to the appropriate Army headquarters, as listed below, reporting where the individual is and the nature of the treatment required. The cost of the telephone call will be reimbursed with the other charges.

The Army headquarters will advise the caller about the administrative management of the patient, and how to submit the bills for service.

Headquarters Fifth

U.S. Army

Commanding General
Fifth United States Army
ATTN: Surgeon
Fort Sheridan, Ill. 60037

Telephone Number:

Area Code 312

Weekdays: 926-3675
Nights, weekends and
holidays: 926-2238

Geographical

Area

Colorado
Illinois
Indiana
Iowa
Kansas
Michigan
Minnesota
Missouri
Nebraska
North Dakota
South Dakota
Wisconsin
Wyoming

Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.

The new filmstrip, "Feeding Your Young Children," is a practical guide for parents to follow in feeding preschoolers. It emphasizes what to feed the preschool child and what to expect in the young child so that mealtime will be a pleasant experience for all. Address order to: National Dairy Council, 111 N. Canal St., Chicago, 60606.

Clinics for Crippled Children Scheduled

Twenty five clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Division will conduct nineteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social, and nursing service. There will be three special clinics for children with cardiac conditions and rheumatic fever, and three for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

May 1—Litchfield—Madison Park School
May 1—Peoria—Cerebral Palsy (A.M.)—St. Francis Community Clinic Area
May 1—Sterling—Community General Hospital
May 6—Alton General—Alton Memorial Hospital
May 7—Hinsdale—Hinsdale Sanitarium
May 7—Fairfield—Fairfield Memorial Hospital
May 8—Springfield—General—St. John's Hospital
May 8—Macomb—McDonough District Hospital
May 9—Chicago Heights—Cardiac—St. James Hospital
May 13—Pittsfield—Illini Community Hospital

May 13—East St. Louis—Christian Welfare Hospital
May 13—Peoria—General—Children's Hospital
May 14—Joliet—St. Joseph's Hospital
May 14—Champaign—Urban—McKinley Hospital
May 15—DuQuoin—Marsh—Browning Hospital
May 15—Elmhurst—Cardiac—Memorial Hospital of DuPage County
May 15—Rockford—Rockford Memorial Hospital
May 21—Evergreen Park—Little Company of Mary Hospital
May 22—Decatur—Decatur Memorial Hospital
May 23—Chicago Heights—Cardiac—St. James Hospital
May 27—Peoria—General—Children's Hospital
May 28—Elgin—Sherman Hospital
May 28—Rock Island—Cerebral Palsy—3808 Eighth Avenue
May 28—Centralia—St. Mary's Hospital
May 28—Springfield—Cerebral Palsy—Diocesan Center

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

Clinical Evaluation of the Pap Smear and the Importance of Followup

BY A. F. LASH, M.D., PH.D./CHICAGO

The importance of the clinical evaluation of the Papanicolaou smear in the screening of the female generative tract cytology can not be overemphasized because of the pitfalls encountered. It is well documented that the detection of the initial stage of carcinoma of the cervix has contributed to the absolute cure rate as well as decreasing the incidence of the invasive stage.^{6,7} However, complete reliance can not be placed on negative pap smear reports in the presence of visible or palpable lesions. According to H. W. Jones, false negative rate may be as high as one third of all patients who truly have carcinoma. All the same, a study of a series of cases by Tuncer, Graham and Graham, to determine the magnitude and the character of badly managed diagnosis, found that general practitioners utilized cytologic or histologic methods only in 60% of the patients seen. Also, the positive pap smear is only an alerting procedure and is not diagnostic. Pap smears of Classes III (repeated), IV, and V demand histologic examination of the suspected tissue to make the definitive diagnosis. The tissue to be examined microscopically may be obtained by punch or cone biopsy and fractional curettage. The degree of anaplasia of the cells is also significant in aiding prognosis. The findings of dysplasia, carcinoma in situ with or without microinvasion, or invasive carcinoma of the cervix warrants complete examination to determine the extent of the lesion. The management will consist of further observation, or of active measures depending on the age, race, parity, period of pregnancy if present and the predictable lack of followup in certain patients.

Previous publications have dealt with confirmed carcinoma in situ with or without microinvasion and followed the course of the severe dysplasia to carcinoma in situ (preinvasive) and then to the invasive stage. All published evidence indicates that about 35-40% of the in situ lesions develop into the invasive stage. However, it has not been proved that all invasive lesions are preceded by the in situ stage. Also, the rate of growth or progression from the preinvasive to the invasive development is variable and the current opinion is that it varies with the age as well as the aggressiveness of the atypical cells and the host resistance of the patient. It becomes obvious that, with all the intangibles which confront us, as clinicians we must judiciously deal with the earliest evidence of abnormal changes in the cells in the asymptomatic patient as well as the patient with symptoms. The majority of the physicians have accepted these principles. But unfortunately, too much reliance is placed on the report of these pap smears without due regard for the physical findings. The following case reports may illustrate this point:

Case Reports

M.C.—52 years of age, G O, had a Pap smear in December because she spotted. It was reported Class I and reassured by her physician that she had senile vaginitis. In June she returned because of continued spotting and he noticed a bluish, hard nodule on the cervix which he at first thought to be a nabothian cyst but when he tried to cauterize it, he found it to be solid. Biopsy of this nodule revealed squamous cell carcinoma of the Cervix. It was judged a State I lesion and a Wertheim hysterectomy was performed and some microscopic right parametrial and bilateral obturator node involvement was found. Postoperative radiation followed with some effect on her right hip joint. She has remained free of the carcinoma but required orthopedic surgery for her hip and walks with a cane.

In this instance, although the Pap smear report was Class I, the fact that the patient spotted and there was a nodule in the cervix, *a diagnostic fractional curettage and four quadrant biopsy would have made the diagnosis six months earlier.*

M.J.—68 years old, G 2, P O, 13 years postmenopausal was a patient in the medical clinic of Cook County Hospital, being treated for hypertension. She had a Pap smear taken as part of the complete examination which proved to be Class V. Since there were no abnormal findings on physical examination, the Pap smear was repeated, to rule out a mix up in patients'

smear. The repeated smear was Class V; therefore, cone biopsy, vaginal nodule biopsy and fractional curettage was performed. The pathology report was chronic cervicitis, vaginitis and atrophic endometrium. The tumor board suggested estrogen and furacin suppositories. After six weeks the Pap smear was found to be Class II. This patient was followed. Three months later peritoneoscopy revealed a right adnexal mass with adhesions.

Abdominal hysterectomy, bilateral salpingo-oophorectomy was performed. Histologic study of the uterus and the adnexa revealed no malignancy. The positive Pap smear was considered to be due to a probable viral vaginitis. The patient has remained under observation and only a Pap Class II has been observed.

In the course of followup, observers are becoming aware of foci of atypical cells in the vagina, in the vault as well as in the lower third of the vagina and on the vulva. The appearance of these unexpected foci has been disturbing particularly when the patient has been assured of cure and may become careless in returning for followup. Therefore, it is of importance to call attention to these multiple or multicentric lesions and to emphasize the importance of followup of all atypical cellular lesions as well as the so-called cured ones.

Research Cited

The incidence of multicentric squamous cell carcinoma of the lower female genital tract has varied in different series. In 1958, Green² and his associates reported multicentric foci in 19.7% of 238 patients with epidermoid carcinoma of the vulva. Moertel, Dockerty and Boggens¹⁰ in 1961 found in their series of 137 patients with carcinoma of vulva and vagina an incidence of 11.7%, while among 823 women with carcinoma of the cervix, 1.1% had discrete squamous cell carcinoma of the vulva or vagina. Also, in 1961, Koss⁵ and his group reported seven patients with a time interval of 1½ to 17 years between the initial treatment and appearance of in situ carcinoma after successful radiation treatment of cervical cancer. Gusberg and Marshall³ (1962) in their study of 327 patients, with intraepithelial carcinoma of



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the cervix, found seven patients with recurrence or persistence of the lesion and three of these went on to develop invasive carcinoma. In 1963, Woodruff and Williams¹¹ reviewed the literature and added 20 patients with multiple sites of anaplasia in the lower genital tract. Currently, in August, 1967, Hansen and Collins⁴ published their experiences with 11 of 105 cases of epidermoid carcinoma of the cervix. Most of the series were retrospective studies. The atypical changes in the squamous epithelium of the lower female genital tract is not only challenging to the cytologist and pathologist, but also to the gynecologist.

Necessity of Follow-Up

The following case reports illustrate why follow-up is mandatory:

E.A.—56 years, white, gravida 2, para 2, Michael Reese Hospital. June 6, 1966: Complaints—vaginal discharge (moniliasis), soreness in vagina. Essential findings: red vagina and cervix, two Pap smears Class V, June 16: Cone biopsy and fractional curettage. Pathology report: Carcinoma in situ of cervix. June 21: Total abdominal hysterectomy with upper 1/3 of vagina, bilateral salpingo-oophorectomy. August 15: Burning in vaginal orifice, multiple red areas around urethra and vaginal orifice. Two Pap smears Class V. Multiple biopsies of red areas and carunculae. Pathology report: carcinoma in situ.

J.R.—71 years, white, Cook County Hospital #17838. January 15, 1964: Carcinoma in situ of cervix. Total abdominal hysterectomy, bilateral salpingo-oophorectomy at another hospital. June 1, 1966: Carcinoma in situ of vaginal vault. Total vaginal colectomy.

G.S.—31 years, Negro, gravida 0, para 0, Cook County Hospital #26006. February, 1964: Pneumonia, Pap smear Class IV. Did not return. June 17: Gynecologic clinic-Pap smear Class V. Biopsy: carcinoma in situ of cervix. July 17: Vaginal hysterectomy, upper 1/3 of vagina. Pathology report: carcinoma in situ of cervix. June 1, 1966: Dysuria, vaginal discharge. Findings: subacute cystitis, invasive squamous cell carcinoma of anterior vaginal wall with invasion into bladder. Refused surgery; is receiving irradiation therapy. Prognosis: poor.

D.P.—33 years, Negro, gravida 2, para 1,

Cook County Hospital #37424. October 1, 1965: Vulvar irritation for ten years, vaginal discharge. Findings: red and white hypertrophied patches on vulva, chronic cervicitis, Pap smear Class IV. October 11: Multiple biopsies of cervix, vagina, vulva and anal skin tag. Pathology report: carcinoma in situ in all. December 16: Abdominal total hysterectomy, total colectomy, simple vulvectomy and resection of anal area. Pathology report: all carcinoma in situ.

G.H.W.—26 years, in 1950—Radical vulvectomy and lymphadenectomy (inguinal, femoral and iliac) for squamous cell carcinoma of the vulva—recurrence in scar removed 1952—recurrence in left buttock excised in 1953—followed until 1962, when she entered because of hypertension (210/100) and cerebral vascular accident. Also, complained of itching perineum. Examination revealed white hypertrophic patches, 1-2 cm. in diameter. Biopsy revealed carcinoma in situ. A month later, expired due to extensive cerebral hemorrhages. Autopsy found no recurrent pelvic malignancy.

Incidence in Practice

In private practice, the incidence of uterine carcinoma (i.e. endometrial adenocarcinoma) is equal to or exceeds that of cervical carcinoma. The same clinical alertness is essential to detect the earliest atypical cellular changes in the endometrium. Certain clinical syndromes such as early dysfunctional menometrorrhagia, infertility, and postmenopausal spotting in obese, hypertensive and diabetic women should arouse suspicions. These symptomatic women require diagnostic curettage rather than cytology studies. But in these elderly ladies who are asymptomatic, adequate recovery of endometrial tissue or cells by the invasion of the endometrial cavity increases the positive results.⁷ The following case reports demonstrate the value of intrauterine aspiration:

A.W.—(reported in 1963) 57 years, white, gravida 2, para 2, 7 years postmenopausal. On routine examination, Pap smear reported malignant connective tissue cells. Four days later, an endometrial biopsy confirmed the diagnosis of mixed cell malignancy of the endometrium. No palpable or visible pelvic pathology. Total abdominal hysterectomy plus upper third colpec-

tomy and bilateral salpingo-oophorectomy. Patient well six years postoperative.

N.T.—white, 64 years, G O, under care for 30 years with minor pelvic complaints. At age 51, a fractional curettage and cervical biopsy was performed for irregular uterine bleeding. Only proliferative endometrium and chronic cervicitis was found. Menopause occurred at age 53. She was very conscientious in returning for 6 month routine examinations. Her annual Pap smears remained Class I until she was 62 years old when it was reported Class III and confirmed 1 month later by a repeat smear—she was completely asymptomatic. One week later, a fractional diagnostic curettage was performed; frozen section revealed adenocarcinoma of the endometrium. A vaginal hysterectomy, upper 1/3 colpectomy and bilateral salpingo-oophorectomy was performed. She is well with negative Pap smears (2½ years postoperative).

The importance of followup was well illustrated in this instance, and the result has been very rewarding.

R.F.—59 years, white, G O, obese, hypertensive and diabetic, was under a physician's care for her medical conditions. At irregular intervals, she came in because of a monilial vulvovaginitis. Her Pap smear was negative. At the age of 48, she experienced some metrorrhagia and was advised to have a diagnostic curettage. Her husband had a heart attack, and since her bleeding had ceased, she decided to postpone her operation. She was seen again seven years later (55 years of age) in the hospital while having her diabetes controlled. Again no palpable or visible pathology was found and the Pap smear was negative. Four years later she returned without any gynecological complaint and her pelvic examination and Pap smear were not significant. Three months later she had vaginal bleeding and this time she consented to hospitalization. A fractional curettage found an adenocarcinoma filling the endometrial cavity down to the internal os which was stenotic. A radical abdominal hysterectomy, bilateral salpingo-oophorectomy and upper 1/3 colpectomy with bilateral pelvic lymphadenectomy was performed. She made an uneventful recovery and was followed for 1½ years, after which she has not returned.

In this instance, the stenotic internal

os prevented the endometrial cells from escaping into the vagina, thereby, giving a false negative smear. The significance of dilating the internal os of the cervix in elderly ladies is well demonstrated.

Aspiration

During the years 1961-63, 576 volunteers were examined by Graham and his associates.¹ Cul-de-sac aspiration produced discomfort similar to that of venipuncture. There were no complications. Thirty percent of the aspiration specimens were unsatisfactory. There were eight positive specimens. Oophorectomy in seven revealed metastatic breast cancer in one, papillary lesions of borderline malignancy in four, a probable borderlike lesion in one and no demonstrable lesion in one. Apparently cells of ovarian cancers desquamate in substantial numbers. If a specimen of peritoneal fluid is obtained from the cul-de-sac, malignant cells should be demonstrable in about 90% of cancer cases. The cytologic examination of cul-de-sac fluid is a promising method of detecting preclinical ovarian cancer. My experience has been limited, but I found it to be a simple office procedure. Although one may not use it as routinely as in the cervical and intrauterine examinations, it is certainly reasonable to use in any patient with an enlarged or hard ovary.

Discussion and Conclusions:

1. The value of the Pap smear as a screening procedure for the detection of malignant cells of the female generative tract has been documented.
2. The clinician must evaluate the Pap smear report whether positive or negative as in any laboratory report in relation to the physical findings.
3. A certain percentage of false negative smears occur in the presence of palpable and visible cervical pathology; therefore, biopsy is essential.
4. Higher incidence of positive Pap smear of the endometrium may be expected with intrauterine aspiration.
5. Preclinical ovarian cancer may be detected by cytologic examination of cul-de-sac fluid.
6. Early detection of cancer of the female generative tract by cytology or histology will convert the prognosis from one of gloom and doom to hope and cure.

(Continued on page 528)

Blood-Oxygen Level Maintenance in Infants

Long-term maintenance of blood-oxygen levels in newborn infants suffering from respiratory distress syndrome may soon become a practical clinical reality with a new artificial lung developed by scientists in the National Heart Institute, a component of the National Institutes of Health.

The NIH scientists, and collaborating scientists in Boston, Chicago, and Baltimore report their use of the highly efficient and disposable membrane lung to safely maintain adequate blood oxygen levels in newborn lambs during continuous use for periods of up to 4 days (96 hours).

Heretofore, prolonged blood-oxygenation with an artificial lung has been limited in duration to less than 12 hours in newborn laboratory animals, and has been accompanied by severe damage to lungs, blood cells and blood proteins, as well as the formation of dangerous blood clots and air bubbles in the blood.

The cylindrical, pint-sized lung, called the "spiral coil membrane lung," contains a thin (5/1000 inch) silicon rubber membrane formed into a flat tube or envelope that is wound about a central spool. The envelop is fitted with oxygen inlet and outlet ports. Blood enters one end of the lung's cylindrical housing, flows between layers of the spirally-wound silicone en-

velope and, still flowing parallel to the cylinder's axis, exists at the other end. As in other membrane lungs, blood oxygen and carbon dioxide exchange occurs by diffusion across a membrane. However, unlike most membrane lungs, the spiral coil lung is suction-actuated, i.e., oxygen is pulled through the lung by the intermittent application of a slight vacuum to the oxygen outlet port.

The new lung owes most of its safety advantages as well as its high oxygenating efficiency to this gentle, cyclic application of negative pressure, as it prevents oxygen bubbles from entering the blood (gas emboli) should pin hole leaks occur in the membrane, and the pulsatile motion it imparts to the membrane greatly increases blood oxygenation by eliminating the "stagnant" boundary layer of oxygen-saturated blood immediately adjacent to the membrane. Thus, more blood is brought into contact with the membrane where oxygenation occurs. Finally, the low perfusion pressure and pulsatile motion, along with normal arterial blood pressure, act to propel blood through the lung and eliminate the need for a separate blood pump with its attendant damage to fragile blood components.

Farm Death Rates

Accidents on American farms, other than those related to transportation, have increased significantly in recent years, according to statisticians of Metropolitan Life Insurance Company.

The 1966 accidental death rate in the farm population was 18.7 per 100,000, or 15 percent higher than in 1961. During this five-year period, the farm population declined by more than a fifth, but the 2,200 farm fatalities reported in 1966 represent a decrease of only about a tenth from the total recorded in 1961.

This higher death rate has been nationwide. In the Mountain region, where the highest accidental death rates usually have been recorded, the rate increased from about 24 per 100,000 during 1960-63 to 27.6 in 1966. In the Northeast region, the rate increased similarly from

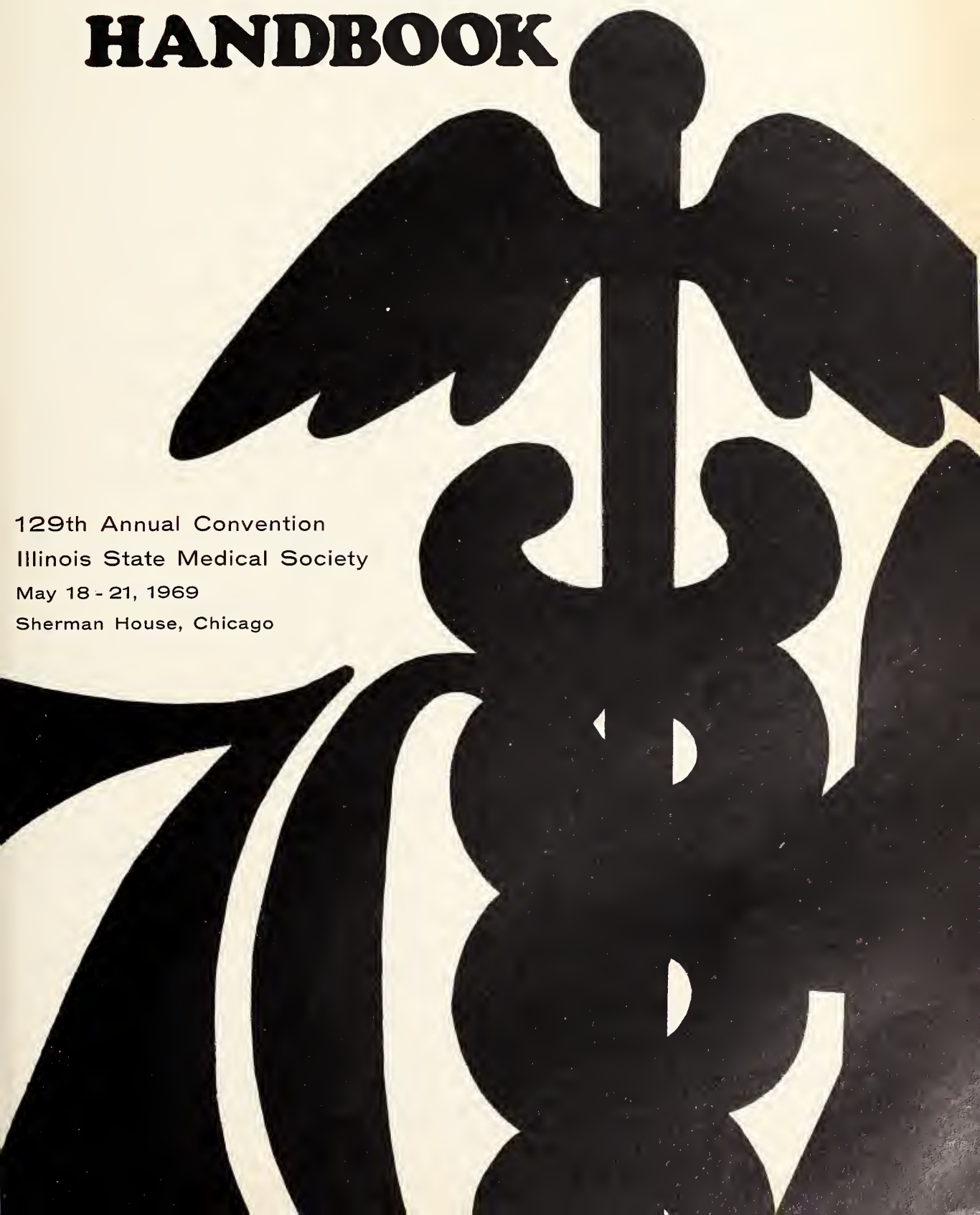
about 21 to 23.5 per 100,000. The Plains States and the Pacific region, ranking third and fourth with respect to the level of the farm fatalities, registered rates of 23.1 and 20.6 per 100,000, respectively, in 1966.

The lowest accidental death rates on the farm in recent years have been reported from the Delta states (Mississippi, Arkansas and Louisiana)—12.3 per 100,000 in 1966.

The accidental farm deaths increased at virtually all ages. The largest rise occurred at ages 15 to 19—from 16 to 20 per 100,000. At other ages, the increase was at least 6 percent. The risk of fatal farm injuries increases from childhood through the early adult ages, but declines somewhat in the late twenties. It starts rising again after age 45, increasing sharply among the elderly to a level far higher than at any other period of life.

DELEGATES HANDBOOK

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	Morgan M. Meyer	John V. Ryan		Fred Z. White	George J. Best
	J. P. Schweitzer	Arthur P. LeBeau	PERRY	C. E. Cawvey	Jas. B. Stotlar
	Wm. E. Hill	Ralph Ryan	PIATT	William E. Mundt	George G. Green
	F. C. Kuharich	Richard P. Muller	PIKE	Myer Shulman	Gene Goodman
EDGAR	J. M. Ingalls	Jos. R. Shackelford	PULASKI	A. L. Robinson	
EDWARDS	Andrew Krajec	Paul S. Neirenberg	RANDOLPH	O. W. Pflasterer	James Whittenberg
EFFINGHAM	Peter C. Rumore	Delbert Huelskoetter	RICHLAND	Chas. A. DeKovesey	William A. Moore
FAYETTE	S. W. Moore	L. G. Oder	ROCK ISLAND	Theodore Grevas	Stuart T. Ramsdell
FORD	Ross N. Hutchison	Edson L. Etherton		C. P. Cunningham	Harold J. Jersild
FRANKLIN			ST. CLAIR	V. P. Siegel	Harold McCann
FULTON	J. K. Welch	Raoul Reinertsen		William Walton	Lloyd Walk
GALLATIN	W. F. Stanelle	John E. Doyle	SALINE-POPE-		
GREENE	Paul A. Dailey	James C. Reid	HARDIN	Warren D. Tuttle	
HANCOCK	Byron I. Mueller	C. W. Bruchsel	SANGAMON	P. V. Dilts	Floyd S. Barringer
HENDERSON	Silvino Lindo, Jr.	Harold L. Bock		Chauncey Maher, Jr.	Earl W. Donelan
HENRY-STARK	Paul M. Schmidt	W. D. Larson		A. R. Eveloff	Ross Schlich
IROQUOIS	R. Kent Swedlund	James E. Dailey	SCHUYLER	Henry A. Zingher	Russell R. Dohner
JACKSON	W. R. Malony	J. P. Goff	SHELBY	H. H. Pettry	Otto Kander
JASPER			STEPHENSON	Thos. A. Haymond	Eugene Vickery
JEFFERSON-			TAZEWELL	Adam Slaw	Robert G. Rhoades
HAMILTON	Robert J. Dancey	David A. Nehme	UNION		
JERSEY-			VERMILION	T. E. Pollard	E. G. Andracki
CALHOUN	Bernard Baalman	Sam Miller	WABASH		
JO DAVIES	C. George Ward	J. Eric Gustafson	WARREN	Richard Icenogle	Russell Jensen
JOHNSON			WASHINGTON		
KANE	Wayne N. Leimbach	Peter Starrett	WAYNE	C. J. Jannings, III	E. S. Talaga
	James A. McDonald	Gerald J. Liesen	WHITE		
	Robert C. Stone	A. B. Johnson	WHITESIDE	John Hubbard	Clarence J. Mueller
KANKAKEE	Dale M. Learned	H. P. Swartz	WILL-GRUNDY	Barry S. Seng	F. Roger Fahrner
KENDALL				Robert J. Becker	John H. Kendall
KNOX	John J. Holland	Homer Fleisher		James H. Lambert	Guy Pandola
LAKE	Charles U. Culmer	John Andrews	WILLIAMSON	Herbert V. Fine	James A. Felts
	Earl Klaren	Eugene Pitts	WINNEBAGO	F. A. Munsey	Robert D. Weber
	John J. Ring	David S. Helberg		L. P. Johnson	R. E. Heerens
LASALLE	Allan L. Goslin	G. A. Neufeld		H. E. LaPlante	F. H. Riordan, III
LAWRENCE	Tom Kirkwood	Gilbert Miller		H. E. Zenisek	E. T. Leonard
LEE				H. T. Barrett	K. Vaicius
LIVINGSTON	Don L. Ervin		WOODFORD		

Agenda

House of Delegates

1969

MAURICE M. HOELTGEN, *Speaker*
PAUL W. SUNDERLAND, *Vice-Speaker*

FIRST SESSION

3 p.m., Sunday, May 18, 1969
The Executive Ballroom, The Sherman House, Chicago

1. Call to order by the Speaker
Maurice M. Hoeltgen
2. Invocation
3. Roll call
Report of the Committee on Credentials
L. T. Fruin, *Co-Chairman*
Andrew J. Brislen, *Co-Chairman*
4. Report of the Committee on Rules & Order of Business
H. E. Zenisek, *Chairman*
5. Approval of the minutes of the May, 1968 meeting of the House of Delegates
6. Remarks of the Speaker
Maurice M. Hoeltgen
7. Memorial service for members of ISMS who have died since May, 1968
Jacob E. Reisch, *Secretary*
8. Introduction of representatives of the STUDENT AMERICAN MEDICAL ASSOCIATION
9. Remarks of the President of the Illinois Chapter, MEDICAL ASSISTANTS ASSOCIATION
10. Report to the House
Mrs. Alden Rarick, *President*
WOMAN'S AUXILIARY, ISMS
11. Introduction of officers of other state medical societies and honored guests
Philip G. Thomsen, *President* (Introduction only, no remarks)
12. Presentation of AMA-ERF Checks to the representative of the five Illinois medical schools
Philip G. Thomsen, *President*, ISMS
13. IMPAC (Illinois Medical Political Action Committee) report
14. President's Address
Philip G. Thomsen, *President*, ISMS
15. Report to the House
Roger N. White, *Executive Administrator*
16. Presentation of the EDWIN S. HAMILTON TEACHING AWARD of the Interstate Postgraduate Medical Association
To: Granville A. Bennett, M.D., Prof. of Pathology and Former Dean, Univ. of Illinois College of Medicine
By: Mather Pfeiffenberger, IPMA Trustee
17. Introduction of supplementary reports
18. Announcement of changes in committees for the 1969 House
Maurice M. Hoeltgen, *Speaker*
 - a. Committee on Credentials
 - b. Committee on Rules and Order of Business
 - c. Sergeants at Arms and Tellers
 - d. Amendments to the Constitution & Bylaws
 - e. Reference Committee on Reports of Officers & Administration
 - f. Reference Committee on Finances & Budgets (Including Journal reports)
 - g. Reference Committee on Economics & Insurance
 - h. Reference Committee on Scientific Services and Medical Education
 - i. Reference Committee on Legislation & Public Affairs
 - j. Reference Committee on Public Relations & Miscellaneous Business
19. Introduction of resolutions and referral to correct reference committees
Maurice M. Hoeltgen, *Speaker*
20. New business and announcements
21. Recess until 2 p.m. Tuesday, May 20, 1969 when the House will hear reports of reference committees.

SECOND SESSION

2 p.m., Tuesday, May 20, 1969
The Executive Ballroom, The Sherman House, Chicago

1. Call to order by the Speaker
Maurice M. Hoeltgen
2. Roll call
Report of the Committee on Credentials
L. T. Fruin, *Co-Chairman*
Andrew J. Brislen, *Co-Chairman*
3. Report of the Committee on Rules and Order of Business
H. E. Zenisek, *Chairman*
4. Announcement of the recipients of the Scientific Exhibit Awards
J. Robert Thompson, *Director of Scientific Exhibits*

5. Introduction of Officers of other state medical societies and honored guests
Philip G. Thomsen, *President*
6. Reports of Reference Committees:
 - a. Constitution & Bylaws—Charles J. Weigel
 - b. Officers & Administration—Fred A. Tworoger
 - c. Finances & Budgets & Publications—William E. Hill
 - d. Economics & Insurance—Clarence Norberg

- e. Educational and Scientific Services—Don L. Ervin
- f. Legislation & Public Affairs—Ralph E. Dolkart
- g. Public Relations & Miscellaneous Business—John Holland
7. Unfinished business
8. New business
9. Recess until 10 a.m. Wednesday, May 21, 1969

THIRD SESSION

10 a.m., Wednesday, May 21, 1969

The Executive Ballroom, The Sherman House, Chicago

1. Call to order by the Chairman
Maurice M. Hoeltgen
2. Roll call
Report of the Committee on Credentials
L. T. Fruin, *Co-Chairman*
Andrew J. Brislen, *Co-Chairman*
3. Report of Committee on Rules and Order of Business
H. E. Zenisek, *Chairman*
4. Introduction of Officers of other state medical societies, and honored guests
Philip G. Thomsen, *President*
5. Induction of Edward W. Cannady, *President-Elect*, into the office of President of the Illinois State Medical Society
By: Philip G. Thomsen, *Retiring President*
OATH OF OFFICE:
(I, Edward W. Cannady, do solemnly swear that I will abide by the Principles of Medical Ethics of the American Medical Association and by the policies of this House of Delegates, and that I will work toward the improvement of the practice of medicine, and the care of the sick in Illinois).
- Presentation of President's Medallion to Dr. Cannady
Philip G. Thomsen, *Retiring President*
- Remarks of the *President*—Edward W. Cannady
6. Presentation of the remaining reference committee reports
7. Elections
Report of the nominating committee
 - a. President-Elect (CMS)
 - b. 1st Vice-President (downstate)
 - c. 2nd Vice-President (CMS)
 - d. Secretary-Treasurer (downstate)
 - e. Speaker of the House (CMS)
 - f. Vice-Speaker (downstate)

- g. Trustees:

District	Term expiring
3rd	Warren W. Young
	J. Ernest Breed
6th	Mather Pfeiffenberger
9th	Charles K. Wells
10th	Willard C. Scrivner
- h. Delegates to the AMA (to take office 1/1/70 and serve for two years to 12/31/71)
Terms expiring:
 - H. Kenneth Scatliff
 - Walter C. Bornemeier
 - Frank H. Fowler
 - Arthur F. Goodyear
 - Harlan English
 - Edward W. Cannady
- i. Alternate delegates to the AMA (to take office 1/1/70 and serve for two years to 12/31/71)
Terms expiring:
 - Harold A. Sofield
 - George C. Turner
 - Edward A. Piszczek
 - Newton DuPuy
 - Carl E. Clark
 - Joseph R. Mallory
8. Unfinished business
9. New business
 - a. Fixing of the per capita assessment for 1970
 - b. Selection of the meeting place for 1972.
 - c. Election of Emeritus, Retired members and those whose dues have been cancelled for cause
Jacob E. Reisch, *Secretary*
 - d. Other
10. Adjournment—*sine die*

REFERENCE COMMITTEE ON LEGISLATION & PUBLIC AFFAIRS

7:30 p.m., Sunday, May 18 Old Chicago Room 101

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

COUNCIL ON LEGISLATION—V. P. Siegel, *Chairman*
MEDICAL-LEGAL COUNCIL—Noel G. Shaw, *Chairman*

COMMITTEES:

PUBLIC AFFAIRS—Theodore Grevas, *Chairman*
EYE HEALTH—Frank J. Kresca, *Chairman*
IMPARTIAL MEDICAL TESTIMONY—
Clinton L. Compere, *Chairman*
MEDICAL PRACTICE & QUACKERY—
William G. McCarthy, *Chairman*
LABORATORY EVALUATION—
Grover L. Seitzinger, *Chairman*
COMPREHENSIVE HEALTH PLANNING—
Task Force—V. P. Siegel, *Chairman*
Ralph E. Dolkart, *Chairman*

Alfred J. Faber
George H. Irwin

Peter Rumore
C. N. Salesman

REFERENCE COMMITTEE ON SCIENTIFIC SERVICES & MEDICAL EDUCATION

7:30 p.m., Sunday, May 18 Crystal Room

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

COUNCIL ON MEDICAL EDUCATION—Jack Gibbs, *Chairman*
COUNCIL ON SCIENTIFIC SERVICES—

Joseph H. Skom, *Chairman*

COMMITTEES:

Alcoholism—Abraham Gelperin, *Chairman*
Cancer Control—John V. Standard, *Chairman*
Child Health—Ralph H. Kunstadter, *Chairman*
Maternal Welfare—Robert R. Hartman, *Chairman*
Mental Health—John R. Adams, *Chairman*
Nutrition—Paul A. Dailey, *Chairman*
Public Health—Edward A. Piszczek, *Chairman*
Narcotics & Other Hazardous Substances—
Joseph H. Skom, *Chairman*
Radiation—Howard C. Burkhead, *Chairman*
Rehabilitation Services—Henry B. Betts, *Chairman*
Medical Education—Morgan M. Meyer, *Chairman*
Continuing Education—
Herschel L. Browns, *Chairman*
Scientific Assembly—Robert T. Fox, *Chairman*
Advisory to SAMA—Norman Frank, *Chairman*

DIRECTOR—Illinois Department of Public Health—
Franklin D. Yoder

DIRECTOR—Illinois Department of Mental Health—
Harold A. Visotsky

Don L. Ervin, *Chairman*

Charles P. McCartney
Burton J. Soboroff

Barry Seng
A. R. Eveloff

REFERENCE COMMITTEE ON ECONOMICS & INSURANCE

7:30 p.m., Sunday, May 18 Gold Room 114

This Committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

COUNCIL ON MEDICAL SERVICE—Fred Z. White, *Chairman*
COMMITTEES:

Prepayment Plans—Preston S. Houk, *Chairman*
Medical Economics & Insurance—
Fred Z. White, *Chairman*
Aging—Thomas T. Tourlentes, *Chairman*
Advisory to Illinois Dept. of Public Aid—
Fred A. Tworoger, *Chairman*
Sub-Committee on Drugs & Therapeutics—
Robert C. Muehrcke, *Chairman*
Usual and Customary Fees—
Joseph O'Donnell, *Chairman*
Advisory to Division of Vocational Rehabilitation—
Eli Borkon, *Chairman*

DIRECTOR, Illinois Department of Public Aid—

Mr. Harold Swank

Clarence A. Norberg, *Chairman*

Clair M. Carey
John M. Coleman

R. Kent Swedlund
R. W. Jost

REFERENCE COMMITTEE ON PUBLIC RELATIONS & MISCELLANEOUS BUSINESS

7:30 p.m., Sunday, May 18 Life Room 108

This committee shall consider and submit its recommendations to the House of Delegates upon the reports of the following committees, and upon any other matters referred to the committee by the Speaker:

COUNCIL ON PUBLIC RELATIONS—

Thomas R. Harwood, *Chairman*

COMMITTEES:

Public Relations—Matthew B. Eisele, *Chairman*
Physicians' Placement Service
Religion & Medicine—
Robert S. Mendelsohn, *Chairman*
Public Safety—Edwin A. Lee, *Chairman*
Disaster Medical Care—Max Klinghoffer, *Chairman*
Membership—Henry A. Holle, *Chairman*
Advisory to Paramedical Groups—
Thomas R. Harwood, *Chairman*
Advisory to Interprofessional Groups—
James D. Majarakis, *Chairman*
Hospital Relations—J. W. Buser, *Chairman*
John Holland, *Chairman*

Eugene T. Hoban
Howard C. Burkhead

L. B. Hussey
C. J. Jannings, III



OFFICERS & ADMINISTRATION

PRESIDENT

During the past year, the President of your Illinois State Medical Society has given thorough and ardent attention to the key problems and challenges of Illinois medicine. He has taken these problems and challenges to physicians at the grassroots . . . to medical educators . . . to paramedical groups . . . to civic and political leaders . . . and to the lay public.

President's Tour—Expanded in format, the second year of the Tour presented a fuller opportunity to carry medicine's message up and down the state. Your President addressed more than 1,000 physicians and wives in 11 cities—Rockford, Carbondale, Joliet, Peoria, Moline, Kankakee, Chicago, Sycamore, Champaign, Springfield and Effingham. He addressed more than 700 community leaders, and discussed controversial issues and the stance of ISMS in TV, radio and newspaper interviews. The Tour was highly successful, and promoted interchange at all levels and at all stops.

Other Meetings—Your President also addressed a Professional Relations Course of the National Association of Blue Shield Plans in Chicago July 16; the ISMS Leadership Conference in Springfield Oct. 6; the Department of Health, Education and Welfare Regional Meeting in Cleveland, Ohio, Oct. 17-18; the Illinois Central Hospital staff in Chicago Oct. 31; the Chicago Medical Assistants Association Nov. 6; the HEW public hearings on Medicaid in Chicago Dec. 30; the University of Illinois Medical College Faculty-Alumni Conference in Peoria Jan. 11, and the IMAA annual meeting at Oak Brook, April 19.

In addition, your President attended the AMA meeting in Miami, Fla., Dec. 1-4; the ISMS Washington Roundup public affairs program in Washington, D.C., Feb. 16-18, and all ISMS executive and Board of Trustees meetings.

Summation: On the President's Tour, in other addresses and on his regular page in the *Illinois Medical Journal*, your President crusaded for fresh, bold approaches in such areas as these: the physician shortage, medical education, medical costs, physicians' relations with public welfare, and social problems. He urged county medical societies to assume a vigorous role in all of these areas and in legislative liaison with ISMS.

The year was busy, but its strains and stresses have been forgotten. What endures is gratitude—for the opportunity to beam ISMS' cause and message in an era of unprecedented threats and challenges to the medical profession. Your President extends this gratitude to the Board of Trustees, officers and staff . . . and to the countless members whose spirit stimulated him.

Philip G. Thomsen

PRESIDENT-ELECT

The past year as President-Elect has been a very interesting and informative one. Our President, Phillip Thomsen, was in great demand and deserves the appreciation and commendation of every member of the Illinois State Medical Society for an outstanding year of service to Illinois medicine. Although it will be very difficult to follow in his footsteps I am looking forward to the opportunity and privilege of serving as your President.

During the Presidents' Tour, I represented our President at Alton, including a press interview and speaking to a workshop on Government Health Programs. It was a pleasure to represent Doctor Thomsen at the annual meeting of the Kentucky Medical Society in Louisville, and the annual meeting of the Missouri State Medical Society in St. Louis.

As a member of the Advisory Committees, I attended numerous meetings of the Illinois Regional Medical Program on Heart Disease, Cancer, and Stroke and the Bi-State Regional Medical Program (Missouri-Illinois) for Heart Disease, Cancer, and Stroke. I assisted in discussing programs on continuing medical education as a member of that committee of the Bi-State Regional Medical Program. The meetings attended for these organizations were held in Chicago, St. Louis, Southern Illinois University (Edwardsville), and Scott Air Base.

As a member of the Board of Directors of the St. Louis Metropolitan Hospital Planning Commission, I attended several meetings regarding the Comprehensive Health Care Program, which is planned for the St. Louis Metropolitan area. A St. Louis Metropolitan Medical Advisory Committee consisting of representatives of several county medical societies in Missouri, and three county societies in Illinois, was organized and all meetings were attended. The primary purpose of this Medical Advisory Committee concerns the proposed Comprehensive Health Care Program for the St. Louis Metropolitan area, but other matters of mutual interest are discussed.

Other meetings attended included the American Medical Association House of Delegates meetings in San Francisco and Miami; meetings of the Presidents and Presidents-Elect of state medical societies (San Francisco, Chicago, and Miami); the Executive Committee and Board of Directors meetings of the National Council for Homemaker Services, Inc., as the American Medical Association representative; Illinois State Medical Society Leadership Conference (Springfield); Southern Illinois Medical Society meeting; meeting of the Executive Committee with the Deans of the Chicago medical schools; all executive committee and Board of Trustee meetings

of the ISMS; Board of Governors' meeting of the American College of Physicians (Colorado Springs), and the Washington Public Affairs Roundup of the Illinois State Medical Society.

It is customary for the President-Elect to be chairman of the Advisory Committee to the Woman's Auxiliary. The committee met with the President and President-Elect of the Auxiliary during the meeting of the Southern Illinois Medical Society. The report and recommendations of the committee were submitted and approved by the Board of Trustees (See report of the Advisory Committee to the Woman's Auxiliary).

Your President-Elect wishes to express his appreciation to Doctor Philip Thomsen, our President, the other officers, the members of the Board of Trustees, and the staff for their splendid guidance and cooperation.

Edward W. Cannady

FIRST VICE-PRESIDENT

No report.

SECOND VICE-PRESIDENT

The office of the 2nd Vice-President carries no duties except as might be delegated by the President; and then only those that are not prohibited by the by-laws of the Illinois State Medical Society.

This has limited activities to a few official appearances to relieve the President and President-Elect in their crowded schedule. Since the by-laws limit appointment to committee membership, this service to the society is not available to the Vice-President.

As a non-voting member of the Board of Trustees, the Vice-President becomes aware of society activities, with freedom of expression. This non-voting status, a House of Delegates edict to prevent undue centralization of power, is probably reasonable and proper. The lack of vote does not compromise the usefulness of this office. The opportunity to keep abreast of society problems and to be available in the event of disaster is well provided for.

Such a passive position, however, is not attractive to an officer who has a sincere desire to work with and for the society. A study should be made to provide this office with meaningful duties which would contribute to strengthening the organization and to provide a training situation for qualified officers to succeed to the administrative offices.

Carl E. Clark

SECRETARY-TREASURER

The report of the Secretary-Treasurer will be found under Finances and Budgets, page 438.

FIRST DISTRICT

The first President's Tour this year was held in this District and proved to be a highly motivating event for all in attendance. The government workshop which was held later in Rockford was heartily endorsed by a large attendance.

Visits to several of the county medical societies in the district have been well received. Members are becoming increasingly aware of the problems generated by the growing government participation in medical planning, of the socio-economic stresses on medical service, and the critical lag in the numbers of clinical physicians

available to provide medical care in the "front line trenches" of our state.

It is encouraging to note the positive and progressive attitude of the leadership, and the willingness to seek out answers.

On the other side of the coin, there are a few minus-apathy on the part of some physicians toward our common problems; geographic differences in community needs leading to disunity (e.g. the physicians in counties close to the Mississippi River are not likely to be in tune with those along Lake Michigan); division of interest along specialty (and sub-specialty) lines splinters the time and energy of doctors away from county and state medical society activity.

It is hoped that all counties of this First District will be visited by July 1st, and that this year's annual meeting will bring these counties closer in spirit.

Joseph L. Bordenave, *Trustee*

SECOND DISTRICT

Second District had the loss of its Trustee for the second straight year. Dr. Ralph N. Redmond of Whiteside County resigned two years ago because of physical troubles from which he has now recovered. Dr. George Giffin, who replaced Dr. Redmond, left the practice of medicine in Bureau County for a residency in anesthesiology.

The Second District had no combined activities this past year.

There has been a loss of doctors for this area, mainly in Bureau County where four doctors left, three to give up G.P. for specialty training.

Whiteside, Bureau and LaSalle counties are doing outstanding work regarding their county medical meetings. Of interest was a program conducted by LaSalle County. Two of their men who left general practice for specialty training gave reports of their reasons for leaving and of the attitude of students in medical school today. From their statements it would appear that efforts of I.S.M.S. to lure young men into general practice are doomed.

W. A. McNichols, *Trustee*

THIRD DISTRICT

All of the Third District Trustees have been very active in medical society affairs. Since the Chicago Medical Society composes the Third District all the trustees have taken an active part in the monthly Chicago Medical Society council meeting. At the CMS council meeting of May 14, 1968, it was announced that Mr. John W. Neal, the Executive Administrator had resigned, effective July 1, 1968. Dr. George Lull agreed to serve as interim administrator and in January of this year Mr. Ernest Guy was invited to assume the administrative responsibilities.

On July 10, 1968, the annual business meeting was held and the new officers were installed. They are Ralph E. Dolkart, President, Fred A. Tworoger, President-Elect, Andrew J. Brislen, Secretary, and H. Kenneth Scatliff was re-elected Treasurer. At the annual dinner meeting held on September 11, the retiring President, Francis W. Young, urged all physicians to take part in the great changes occurring in medicine and in society in general.

There are five medical schools in the Third District, making this area one of the major medical centers of the world. Last fall, the CMS organized two post-graduate courses, one in internal medicine and the other in ob-

stetrics and gynecology. More applicants than could be accommodated applied for each course.

A leading part in the establishment of the Area Wide Agency of the Comprehensive Health Planning law was assumed by the CMS and the council voted \$25,000 for our share in this venture. In addition, a new public relations firm has been employed to help publicize the role of organized medicine in the county.

Arrangements have been made for the annual CMS Midwest Clinical Conference always held the early part of March.

REPORTS OF INDIVIDUAL TRUSTEES

Frank J. Jirka will make his report elsewhere as Chairman of the Board of Trustees of ISMS.

Warren W. Young, has established and chairs the Medicine and Religion Committee for the Third District. He also has taken an active part in the Chicago Hospital Council Emergency Room Affairs.

William M. Lees has delivered two talks to branch meetings on federal legislation and its effect on patient care. He also has taken part in a panel before the Illinois Operating Room Nurses Association on the terminal patient and appeared in a movie for medical schools on the morality of life extension measures. Dr. Lees also chairs the ISMS Finance Committee.

William E. Adams has been active as assistant director of the American College of Surgeons. In this strategic position he has constantly served the interest of physicians and has worked closely with the AMA in many significant areas. In addition, in his activities as Chairman of the Osteopathic Study Committee and the Policy Committee of the ISMS, he has diligently worked for the society.

J. Ernest Breed has been quite active appearing on six radio and two television shows, usually in the area of ethics and life extension. In addition he has spoken before hospital groups and on a panel for seminary students, he appeared with Dr. Lees before the Illinois Operating Room Nurses Association and on the motion picture film for medical schools. As Chairman of the CMS Committee On Legislative Information, he has kept the Third District members informed on legislation and has prepared an exhibit on Comprehensive Health Planning law to be shown at the CMS Midwest Conference.

James B. Hartney's activities have been primarily concerned with laboratories and blood banks. Chairing the state committee, he has drafted changes in the Illinois Laboratory Licensing Act and legislation to make the provision of blood a service not a commercial proposition. He appeared before a meeting in Jackson, Miss., in March as a member of the AMA Blood Bank Council.

William E. Adams, *Trustee* Frank J. Jirka, *Trustee*
J. Ernest Breed, *Trustee* William M. Lees, *Trustee*
James B. Hartney, *Trustee* Warren W. Young, *Trustee*

FOURTH DISTRICT

During the past year our component societies have been active on both the local and state levels as is evidenced by the increase in the appointments at the state level. A number of our members were seen at the leadership conference in Springfield. Other activities were those of the excellent program on Nutrition with an attendance of several hundred persons. Also of equal importance was the Public Affairs Conference when we had the pleasure of Congressman Ford as speaker. The highlight of the year was, no doubt, the program, the President's Tour, and the accompanying workshop.

The urgent demand for more general practitioners, in every district of the state, is the cry of our district. It seems that this form of practice has become obsolete and that as time goes on we can expect only specialists to fill the small array of our general practitioner. For many years, our hopes have lifted that the fruition of the efforts of Peoria County could be realized in the establishment of a medical school in that city. The facilities and personnel are there, and we are regimented.

At the present time, the Rock Island County Society, with several adjoining counties, is contemplating the feasibility of employing a full time secretary to the end that the continuity of activities within our societies might be maintained.

May I express my gratitude to the officers of the component medical societies and the headquarters' staff, for the cooperation and courtesies shown to me.

P. P. Youngberg, *Trustee*

FIFTH DISTRICT

It is hoped to have an Annual District Meeting. This meeting will be a combined President's Tour with a Workshop dealing with economics, legislation, public affairs, or other subjects pertinent to the times.

The many advantages of this opportunity for a well planned meeting by our very apt staff, and council and committee chairmen, are readily apparent. Once planned, this can be given in one or all of the eleven Trustee Districts, as desired by the membership.

This should also afford a forum for the component society's officers and delegates for open discussion and enlightenment. These meetings will involve certain ISMS funds. However, this will only involve budgetary adjustments and not additional funds; in fact it should bring about economies, not only of funds but our busy President's time.

Such a meeting was planned for March 27th in Springfield. Combining a "Workshop on Government Health Programs" and "The President's Tour." We anticipated good attendance. It was my greatest concern that the county officers and delegates avail themselves of this opportunity near home.

Your Trustee has had the good fortune to attend all Board meetings, save one. I have always been a staunch advocate of having at least one Board meeting down-state every year, so that all interested officers and members could witness the deliberations and proceedings. Ironically, because of a prior commitment to attend an International Congress on Chest Diseases in Washington, D.C., I missed the Oct. 5th meeting in Springfield. This was a combined meeting with the Leadership Conference, previously scheduled for April, 1968. Another down-state meeting is planned for fall, 1969.

Springfield continues to be "The Focal Center of Medicine For Central Illinois," as carried on the cover of the "Bulletin of the Sangamon County Medical Society." Some of the highlights are as follows:

In order to keep abreast of the rapidly changing socioeconomic and medical education picture it has been necessary to employ a part time Executive Secretary, Mr. L. R. Brosi, a mature man, well versed in public relations work.

The two Springfield hospitals have each employed four full time physicians to man their emergency rooms on a full time basis.

Springfield Memorial Hospital is completing an expansion program and has established a respiratory care unit, a rehabilitation unit, and a renal dialysis unit; a burn center is in the present plan.

St. Johns Hospital is well underway on the first phase of a \$20,000,000 expansion and replacement program.

A Sangamon County Medical Society committee is working closely with Southern Illinois University in establishing a medical school and the use of Springfield facilities to the fullest extent. In due time this should assist in relieving the shortage of general practitioners in Central Illinois as well as other areas of the state.

The number of members in the Fifth District remains practically the same, and there is a great need for more general practitioners in all counties, and especially in the less populous areas.

Apathy and poor attendance at meetings continue to plague our county societies. This same apathy invaded our delegate strength in the 1968 House, with less than 50% attendance at meetings of the House, Delegate District luncheon, and the caucus.

County nominating committees please take note: This lack of participation not only deprives you of representation at the annual meeting, but may allow a worn out or mediocre Trustee to represent your District for another three year term. Another District luncheon has been planned for the opening day of our annual meeting in May. I hope for full attendance.

I have endeavored to remain active on the assigned Trustee Committees. As chairman of the Committee on Committees, we have tried to correct and strengthen the relatively recent Council and Committee structure. I also have served as a member of an Ad Hoc Committee dealing with this same problem, but from a little fresher and possibly more experienced viewpoint. As a member of the Publications (Journal) Committee, we are constantly striving to make all publications more useful in all phases to the membership as a whole. This is a very active committee and meets frequently.

May I express my appreciation for the co-operation and continued support of the constituent medical societies and Mr. Roger White and his staff in Chicago and Springfield. I am very grateful to our members serving on the various Councils and committees unselfishly and with distinction. I am very grateful to the officers and fellow trustees for their consideration and kindnesses this past year.

Darrell H. Trumpe, *Trustee*

SIXTH DISTRICT

A Sixth District meeting of delegates and alternate delegates will be held in Jacksonville in early May. This will be a pre-convention gathering 1) to study resolutions which are to be presented to the House of Delegates and 2) to consider any problems in the counties making up the Sixth District which might require action at the district or state level.

During the past year no problems have arisen which required consideration by the district Ethical Relations, Grievance, or Prepayment Plans and Organizations Committees. A very successful and well attended Sixth District Conference was held on October 2, 1968, in Alton. This consisted of an afternoon Government Health Programs Workshop and an evening dinner meeting at which ISMS President-Elect Edward Cannady and Illinois House of Representatives Speaker Ralph T. Smith discussed socioeconomic and legislative health issues.

Comprehensive Health Planning programs are progressing in Adams, Madison, and Morgan counties. Several members of the Madison County Medical Society are actively participating in the Bi-State Regional Medical Program which serves the greater St. Louis metro-

politan area. Several major expansions of hospital facilities are progressing in Greene and Madison counties. A new dental school is being planned at the combined Alton-Edwardsville campuses of the Southern Illinois University.

The frustrating problems of billing procedures for both IDPA and Medicare patients are common throughout the Sixth District and are a source of great annoyance to the conscientious physician. Little noticeable improvement has occurred in solving these problems in the past year.

I have attended all meetings of the Board of Trustees and have served on several Board committees during the past year. I wish to thank Mr. Roger White, our able new Executive Administrator, and all personnel in the Chicago and Springfield offices of the ISMS who have so willingly helped me during this year past.

J. Mather Pfeifferberger, *Trustee*

SEVENTH DISTRICT

A telephone canvas of the component societies in the District brought forth a request from each that we obtain, if possible, more general practitioners. Attrition by death and retirement, without replacement, is creating an embarrassing crisis.

Leadership is being taken on Comprehensive Health Planning. Socio-economically, fee stabilization has not been a problem in this District. The Regional Medical Program is being worked on and the overlap of the Missouri-Illinois area apparently has been resolved.

The Preceptorship Program Plan has aroused interest, particularly in the Macon County Medical Society. It is hoped by this Society that such a program can be accomplished in Decatur.

Solutions to the problem of hospital emergency service are being sought.

Since the recognition of qualified Osteopathic physicians has been made, there have been no reports to your Trustee of applications to any of the component societies.

The Ethical Relations, Grievance, and Prepayment Plans Committees have not been called on for meetings this year.

One Fifty Year Club Award was made March 31, 1968, to Dr. A. D. Furry, Monticello, at a special meeting held by the Piatt County Medical Society. Your Trustee took the privilege of naming Dr. Cincy Rich of Decatur, a long time friend of Dr. Furry's, to present the Certificate and Pin.

The Woman's Auxiliary has been working actively in its field. This is always appreciated.

To summarize, the constituent societies of the Seventh District are successfully processing Educational, Socio-economic, Health Planning and Regional Medical Programs.

Your Trustee wishes to express his appreciation to the Component Societies of the Seventh District and their Auxiliaries for their generous support and cooperation.

Arthur F. Goodyear, *Trustee*

EIGHTH DISTRICT

See report published on page 479.

NINTH DISTRICT

The Trustee of the Ninth District has been rather inactive during the past year, as have most of the Societies in his district. No invitations have been extended the Trustee to visit any of the Medical Societies within the

district, and no problems have arisen requiring the use of the Ethical Relations, Grievance or Prepayment Plan and Organization Committees.

An attempt was made to have the State President at a District Workshop meeting on Government programs, but lack of response to attend the meeting forced cancellation.

The combined district meeting of the Ninth and Tenth Districts was held in Belleville, at Augustine's Restaurant, November 7, 1968, and was well attended.

I have attended all but one of the Trustee meetings held during the past year; illness in the family prevented my attending this meeting.

The Illinois State Medical Society staff has been very cooperative and helpful in sending out various notices to members of the district, and my congratulations are extended to them for their help.

Charles K. Wells, *Trustee*

TENTH DISTRICT

May 1968—February 1969

CATEGORIES OF ACTIVITIES AND MEETINGS ATTENDED

- 1) County Societies
 - 2) AMA—Miami and San Francisco
 - 3) Regional Medical Program (Bi-State)
 - 4) Comprehensive Health Program (Bi-State)
 - 5) Belleville Area College, Department of Nursing
 - 6) Leadership Conference—Springfield
 - 7) Nurse Scholarship Association of St. Clair County
 - 8) Health Guide Program
 - 9) Public Affairs Conference—Washington, D.C.
- 38 meetings, plus all meetings of ISMS Board of Trustees

HIGHLIGHTS OF EVENTS IN DISTRICT

- 1) President's Tour—Jackson County
- 2) Joint meeting Districts 9 and 10, Belleville; in conjunction with Southern Illinois Medical Society.
- 3) Workshop on government forms—Belleville
- 4) Nurse Scholarship Association of St. Clair County tea and banquet
- 5) Hospital expansion, education programs on part of staff at several hospitals in district.
- 6) Formation of Metropolitan Medical Advisory Council for Bi-State.
- 7) Innovation and development of Health Guide Program—"Central City" East St. Louis.
- 8) Postcard survey of 10th District physicians' recommendations for improved and sustained service of ISMS to its members.

PHYSICIANS AND FAMILIES HAVE—

- 1) A sustained interest in legislation activities and public affairs.
- 2) A great concern over physician shortage and delivery of health care.
- 3) A commendable involvement in community programs and projects with leadership role in developing solutions for areas of social distress.
- 4) Fostered a genuine effort to expand medical education with special attention to Southern Illinois.

W. C. Scrivner, *Trustee*

ELEVENTH DISTRICT

Since the annual meeting of the House of Delegates in May, 1968, your Trustee has attended the following meetings:

- 1) Proceedings of the House of Delegates of the AMA in San Francisco, June 1968, as an observer;
- 2) All ISMS Board of Trustees meetings;
- 3) A District Conference held in conjunction with the President's Tour in Joliet in October;
- 4) Secretary's Regional Conference on Medical Care Costs in Cleveland, as a representative of ISMS.

Personal visits to the individual county medical societies of the 11th District are scheduled for the next few months. There also was a meeting of the AMA Council on Socio-Economics scheduled in March, to be attended as a representative of ISMS.

During the past year your Trustee also served as chairman of two Board committees: *viz*, the Usual and Customary Fee Committee, and an ad hoc Committee to Study Revisions of the Council Structure of ISMS.

It is my sincere desire that all the delegates avail themselves of the opportunity to obtain the full minutes of the Board of Trustees meetings from the state society office, which are available only upon direct request. The proceedings are detailed but frequently require further explanations for which I would most willingly be of service.

The structure of committees of ISMS makes it imperative that all Districts, county medical societies and all other facets of medicine be equally represented in order to reflect the true policy of ISMS. Your participation is essential.

In the past there have been surveys made on various subjects, *e.g.*, the recent socio-economic survey. Although membership response was fairly good (3,000 out of a potential 9,500) it was important that each doctor respond so that his opinion would be made known.

Major issues are now confronting the medical profession. The more informed and responsive this society is, the easier our task will be in meeting changes.

Joseph R. O'Donnell, *Trustee*

TRUSTEE AT LARGE

This year as Immediate Past President has been a pleasant epilogue and it is with some regrets that I write my last report as a Trustee. To leave the warm and pleasurable company of the Board is not to my liking. I will miss the chores occasionally assigned to me. The inimitable Boswell has written meaningfully in this regard: "There is a pleasure, when one is indolent, to think that a task, to the performance of which one has been again and again subjected, and had some difficulty to make it out, is no longer to be required. But this pleasure, or rather comfort, does not last. For we soon feel a degree of uneasy languor, not merely in being without a stated exercise, but in being void of the usual consciousness of its regular returns, by which the mind has been agreeably braced."

My years on the Board of Trustees have afforded me the opportunity to be associated with physicians of the highest caliber, physicians of dedicated purpose and high ideals: some more outstanding but all gentle men who have enriched my life and I leave them reluctantly. I should like to say a proper thank-you to the officers and to the members of the Board of Trustees for their considerable help, for their loyalties, and for their friendships. My sincere thanks also to the Directors and their staff, to Mrs. Frances Zimmer and to the Executive Administrator, Mr. Roger White.

Newton DuPuy, *Trustee*

CHAIRMAN OF THE BOARD OF TRUSTEES

The Board of Trustees has completed a demanding, yet rewarding, year. In its efforts to improve ISMS service to members and strengthen communications at the grass roots level, it has established a number of dramatic and pioneering programs which are being received enthusiastically across the state.

In order to avoid duplication, my report will be concerned with those items acted upon by the Board of Trustees which do not pertain to any existing Society committee, and which will not be reported upon elsewhere.

Opinion Survey

To determine first hand the needs and attitudes of the membership, an opinion survey was developed over the summer months of 1968 and distributed to all ISMS members through the Committee on Public Relations. Containing precise and comprehensive questions on timely medical-legal, socio-economic and professional practice concerns, the survey was formulated to serve as a basis for action by the Board and to supply topical guidelines for the ISMS President on his statewide President's Tour.

Your Board chairman and the other officers were gratified by the enthusiastic response to the survey by the membership. The answers provided in many instances were restated as specific problem areas and referred to appropriate committees for study and recommendation. The policies derived from these recommendations will, we are certain, more truly reflect medicine's needs in Illinois.

Downstate Meetings

A further attempt to establish closer relations with the membership was realized over the past year in scheduling Board meetings for downstate locations—away from Chicago. The October, 1968, Board meeting—held in Springfield—was highly successful and proved conclusively that the participation of physicians at the local level is essential to an active and smooth-running ISMS operation.

Internal Communications

To facilitate reporting mechanisms and strengthen internal communications, the Board last year developed a system allowing for greater application of committee reports to the councils and council reports to the Board. In addition, an ad hoc committee to study council/committee structure has recommended still other refinements in the system which are reported elsewhere. Implementation of these recommendations, currently under study by the Board, will ensure that all actions taken in the future accurately reflect the wishes of the membership.

Another significant action during the year was the establishment of regular meetings between the Board chairman and division directors of the ISMS staff. The meetings have resulted in far greater rapport and understanding between Board and staff with regard to ISMS programs and the desires of the Society.

Executive Administrator

A professional Society can be only as good as its professional staff. For this reason, the Board was pleased at its 1968 meeting to appoint Mr. Roger N. White as executive administrator, succeeding Dr. George F. Lull.

Over the past year, the confidence placed in Mr. White by the Board has proved well founded. In every way he has been a dedicated and capable administrator, working tirelessly and effectively for the highest principles of the medical profession. He has done a yeoman's job in organizing his staff, directing its affairs, and successfully following through on many arduous tasks.

The Board wishes to express its thanks to Mr. White, to all division directors and to all staff at ISMS headquarters, whose cooperation and faithful service have contributed significantly to a successful year.

Priority List for Society Activities

The development of a careful study and priority list for Society activities has been undertaken by headquarters staff. It is hoped that all divisions at headquarters will be able to concentrate their activities in those areas most in demand by the membership of the Society and furnish the members with the services they most desire and logically expect as a part of their dues structure.

All trustees have been requested to make a written report of each county society in their District, giving the strong points and the outstanding programs under way, as well as the areas in which other counties might need assistance. In this manner it may be possible to personalize some of the services available to local societies.

Qualifications to Practice Medicine

Various methods of determining whether a physician is scientifically qualified to practice medicine were discussed by the Board. This was considered as a possible responsibility of the local county society. If any physician is adjudged unqualified as a result of action taken by his local county medical society, the question of liability immediately arises. ISMS general counsel will have to make a study of this problem. The Board considers the maintenance of high standards in all medical practice requisite and the matter will be studied in detail. The profession must develop some means by which it is able to judge itself, for if it does not the federal government will surely step in and demand special re-examination, re-licensing, and a program of continuing education for the practicing physician.

Medical Advisory Committee to Department of Vocational Rehabilitation

The importance and the extent of the work of the Department of Vocational Rehabilitation was considered by the Board. A suggested Medical Advisory Committee to this Department, to function in a manner similar to that of the Medical Advisory Committee to the Department of Public Aid, was approved. A committee of this type will work efficiently and successfully since the Department desires the service. After several meetings with Mr. Alfred Slicer, Director of the Department, the functions of the new committee are to be outlined.

Impartial Medical Testimony in Malpractice Suits

The use of impartial medical testimony in malpractice suits has been discussed many times. It is possible for the court to request this type of cooperation from the medical profession. In the opinion of the Board, this area should not be covered by the same panel pro-

viding testimony in personal injury cases under the Impartial Medical Testimony program developed several years ago.

New Jersey has a plan in operation to provide impartial consideration of malpractice cases. The Medical Legal Council (of which Dr. Noel G. Shaw is the chairman) is studying this problem and it is possible that they will have recommendations to make at a later date.

Pilot Program in Clark County

Dr. Eugene Johnson, of Casey (Clark County), appeared before the Board and requested approval of a plan whereby Clark County physicians would submit bills for patients jointly covered by Medicare and IDPA, without accepting the Medicare assignment.

The physicians would expect IDPA to pay the \$50 deductible, not payable under Medicare. They would accept this \$50 plus 80% of the allowable charges paid by Medicare as payment in full for these patients. Dr. Johnson will probably report on the present situation in Clark County, and whether this pilot program has been successful during operation.

Records to State Library

The Board approved cooperation with Mr. William K. Alderfer, State Historian. Any ISMS records of historical value or interest will be sent to the Illinois State Historical Library in Springfield. Material so deposited will be available to anyone desiring to study or review it. By proceeding in this manner, the records of the Society will be protected, and the problem of supplying storage space for important portions of the archives will be solved. It is interesting to note that the collection of photographs made by Dr. Carl E. Black of Jacksonville is already deposited in the Historical Library and is the largest single collection of pictures of physicians outside those on file with the Armed Forces. This gift to the Library was the first of its kind, and provided the nucleus for these and future deposits.

Committee on Corporate Practice

To study the concept and inherent problems of corporate practice as applied to medical practitioners, an ad hoc committee was appointed. The charge to the group was to study and make information available to the state and local societies, especially if legislation developed. If legislation making corporate medical practice illegal were passed, very serious consequences might arise. This would, for example, bring under scrutiny the employment of physicians in hospital emergency rooms. (It has always been unethical for a physician to "sell his services" or for an employer of a physician to make a profit over and above the employed physician's salary.)

A plan has been developed "to distribute the fees collected for services rendered paying patients by salaried physicians." The plan has been implemented at the University of Illinois Research and Educational Hospitals and at Cook County Hospital. It was the opinion of the Board that the medical group earning these fees should retain control of the expenditure of the sums collected and be responsible for the planning and expenditure of accumulated amounts.

Ethical Relations and Legal Counsel

Representation of an accused by legal counsel, in an ethical relations case heard at the local county level, has

been creating some problems. The House may be asked to consider the statement in the By-laws, and perhaps remove it, to mitigate the local hearings. Thus the By-laws would be changed by the deletion of the phrase "and/or by legal counsel." This statement allows the accused to appear before the local ethical relations committee with counsel and in many cases it is then imperative for the county society to be likewise represented. The "hearing" takes on all aspects of a legal case in court.

Dues for 1970

In compliance with the request from the House, the policy approved by official action is as follows:

"The chairman of the Board shall place the question of dues for the coming year on the agenda for consideration at the spring meeting of the Board.

"Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year, shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. The recommendation shall also be published in the *Illinois Medical Journal* as a part of the annual report of the Chairman of the Board. . . ."

Therefore, I at this time report to you that the Board of Trustees will not request an increase in dues for the year 1970—but will recommend that the House approve the same dues structure as in effect for 1969.

AMA-ERF	\$20
Permanent Reserve	8
Benevolence	5
HCCI	2
General Funds	70
	—
Dues for 1970	\$105.00

(Prior to the meeting, the annual audit by Peat, Marwick and Mitchell for 1968 will be made available, as well as revised budget estimates for the balance of 1969 and for 1970.)

Frank J. Jirka, Jr.

EXECUTIVE ADMINISTRATOR

The transition from the former administration to the present administration was officially completed July 1, 1968. I wish to express my appreciation to Dr. George F. Lull, Interim Executive Administrator, for the excellent cooperation given and for the fine manner in which the affairs of the Society were transferred to me. The cooperation of the staff during this period was most exemplary. The work of the Society has gone forward without interruption.

All resolutions adopted by the 1968 House of Delegates and other directives have been referred to appropriate committees for implementation. Progress on activity will be included in the various reports presented to the House of Delegates. During the year, a high priority has been given to the acute shortage of physicians, retention of medical school graduates for practice in Illinois and measures to interest medical graduates in family practice. In a February 1 meeting between members of the Executive Committee and the Deans of the Medical Schools, the crisis in physician supply was brought home most forcefully. The Board of Higher Education Study has further focused attention on this problem. Let us hope others will join the ranks of Illinois medicine in the fight for more physicians.

As reported to you elsewhere, the finances of the Society have been maintained in good order without deficit spending during the year. Steps have been instituted administratively to provide for competitive bidding on materials and services purchased from outside suppliers. A close personal scrutiny has been given to all expenditures to assure that each dollar of membership dues is being wisely spent. Members of the House should be aware that inflation places a constant strain on the budget. The 4.2% increase in the BLS Index for 1968 would normally call for an increase of approximately \$25,000 in expenditures to maintain the 1967 level of program. The 1968 experience shows us well below that figure. A modest increase of \$10,000 or 1.1%, has been allowed in the 1969 projection. This, of course, will not cover the increased cost of doing business. Our projection is based upon the assumption that we can and will effect further economies in operation during 1969. Members of the House of Delegates should be aware that this attrition from inflation cannot be offset indefinitely by this method. As inflation takes its toll, it will be necessary to gradually draw upon amounts currently being utilized to build reserves. Barring unforeseen happenings which would require unusual expenditures, the present dues structure should be adequate for several more years.

The demands for new services within the Society are limited only by the imagination of the membership. To accede to these requires either the elimination of some current services or an increase in staff and program expenditures. To meet this challenge, the Executive Committee and the staff have embarked upon a program of priority planning as mentioned in the report of the Chairman of the Board. Such planning frequently runs counter to certain traditions and favored activity. Nonetheless, changes must be made if the Society is to maintain a position of leadership in the medical field.

Likewise, the committee and council structure of the Society must be geared to meet the changing needs of the times. Some committees which loomed large in importance in the past, no longer have a viable function pertinent to today's needs. Accordingly a program has been instituted to evaluate and propose needed changes in the council and committee structure. The expense of maintaining committees for relatively unimportant assignments consumes sorely needed dollars and staff time.

I wish to commend the staff for their dedicated support throughout the year. Many have performed services well beyond the normal requirements. This type of dedicated service is difficult to find in this day and age and represents a treasured commodity of great value to the Society. I should like also to commend the Officers and the Board of Trustees for their dedicated service. These men have served diligently and at great personal sacrifice to themselves and to their families. Your Executive Administrator has many occasions to call upon them for assistance. Not once has this assistance been refused.

In conclusion, may we be reminded that the test of an organization's greatness lies in its ability to provide leadership to its own members and to the public at large. The most serious challenge to medical leadership lies in the health care delivery system. Much of the influence which rightfully belongs in the hands of the practicing physician who is called upon to deliver the service has been lost to others. Bold and imaginative leadership is required to develop acceptable alternatives to unacceptable programs. A concerted effort is needed to place more practicing physicians on important Boards, Commissions, and in the seats of power within government and outside of government. The necessary resources

are available in abundant quantities among the membership of this Society. Your staff stands ready to aid you in further marshalling these resources to provide the strongest possible voice for the physicians of Illinois.

Roger N. White

SPEAKER OF THE HOUSE OF DELEGATES

The Speaker and the Vice Speaker will continue to incorporate in their planning any material called to their attention by members of the House to improve the efficiency and the services of this policymaking body to its members and to the members of the State Society at large.

The personnel of the reference committees has been appointed and the committee reports assigned. This information appears elsewhere in this Handbook.

As Speaker may I take this opportunity to ask all delegates and alternate delegates to review the reports carefully, and discuss any controversial problem or policy-making statements with the members of their county or branch society.

The importance of attending *ALL THREE MEETINGS* of the House of Delegates will be particularly stressed by the Speaker this year. A delegate should see that all material is introduced before the first meeting of the House—note where it is referred—and plan to attend the reference committee meetings that same evening.

The reports of these reference committees have no standing and are not official until such time as the House has accepted, modified, or amended the recommendations. As a delegate it is your responsibility to vote and represent your county society at the time these reports are made at the *SECOND MEETING* of the House on Tuesday afternoon, May 20.

The election of officers, trustees, delegates and alternate delegates to the AMA takes place at the *THIRD MEETING* of the House on Wednesday morning, May 21. Nominations are accepted from the floor if the slate presented does not represent the general consensus. If there are two candidates for one office, written ballots will be provided. When there is only one candidate for any particular office, a voice vote is in order.

When the meeting adjourns sine die, it is the responsibility of each delegate and/or alternate delegate to take back to the members of his county or branch society the highlights of the meeting. A general summary is prepared as quickly as possible by headquarters staff and mailed to all officers, trustees, delegates and alternate delegates and all presidents and secretaries of county and branch societies.

The pamphlet "Your Role as a Delegate" will be distributed in the material passed out at the opening meeting of the House.

Again this year, identifying badges will be provided all *VOTING* members of the House. Having your alternate seated officially and given a correct badge as a *DELEGATE* if you are unable to attend will provide him the only means by which he may vote in the House.

Resolutions will be accepted as long as the headquarters office can handle them and prepare the official copies for distribution. All must be given identifying numbers, and referred to the correct reference committee for study and subsequent report.

The meetings of the House this year will be:

SUNDAY, May 18

- 2:00 p.m. Committee on Credentials
- 3:00 p.m. **OPENING MEETING OF THE HOUSE.**
Introduction of Resolutions, reports, etc., and referral to the correct reference committee by the Speaker
- 7:00 p.m. Reference Committee meetings
Open meetings at which all who are interested will be welcome

TUESDAY, May 20

- 1:30 p.m. Committee on Credentials
- 2:00 p.m. **HOUSE OF DELEGATES—Second Session**
To hear the reports of reference committees ready to report

WEDNESDAY, May 21

- 9:30 a.m. Committee on Credentials
- 10:00 a.m. **HOUSE OF DELEGATES—Third session**
Closing session
To hear remaining reference committee reports
Election of 1970 officers, trustees, AMA delegates and alternate delegates
Induction of Edward W. Cannady into the office of President

At this writing (March 10) only seven resolutions have been received; many others will not make the deadline for publication in the *Illinois Medical Journal*.

My hope for improving the procedures followed by the House includes mailing out to all members resolutions as they are received (after the deadline of the *Journal* has passed.) The headquarters office will try to follow this suggestion this year, especially if the resolution represents a controversial problem which should be presented to the county societies for an opinion prior to the discussion by the reference committee and the final policy-making vote by the House.

In some cases, county societies "instruct" their delegates how to vote on certain controversial issues. I would hope that this action to bind a delegate would be removed if the delegate finds that information is being furnished the House which was not available at the time the local society considered the problem. The ability of the delegate to represent his society carefully and honestly should be weighed against the problem he might face if he were "instructed" in any particular area and unable to use his own good judgment.

Any suggestions which might produce more efficiency in the procedure of this House will be most welcome and sincerely appreciated by the Speaker.

Maurice M. Hoeltgen

VICE SPEAKER

The most stimulating aspect of this office is presiding at your House of Delegates meeting. I anticipate seeing you at this time.

The most challenging job is the equitable selection of delegates for reference committees. This year so many counties had not reported their delegates by the deadline for publication that some of you may not be well represented. Try to have your county secretaries report delegates early in January.

The reward of the office is serving you, assisting with a smoothly functioning meeting, and helping you with problems relative to the aim of representing the doctors of our state in ISMS.

Paul W. Sunderland

DELEGATION TO THE AMA

Some of the efforts on the part of members of the Illinois delegation to the American Medical Association to extend the influence of our able and well-informed delegation have begun to take effect. At the last meetings of the AMA, both annual and clinical sessions, Walter C. Bornemeier has served as the Speaker of the House; and after the close of the San Francisco annual meeting, Burtis E. Montgomery was elected as the chairman of the Board of Trustees. They served in these two capacities at the Miami Beach clinical session.

All delegates were present at both meetings during 1968. At the San Francisco meeting Harlan English served as a member of the reference committee on amendments to the constitution and by-laws and Arthur F. Goodyear on the committee on credentials. In Miami, Frank H. Fowler chaired Reference Committee E, to which was referred problems dealing with scientific programs and public health; Arthur F. Goodyear was a member of Committee B which handled legislation and H. Kenneth Scatliff was on the credentials committee.

The Illinois House of Delegates, at its 1968 meeting, requested the AMA delegation to outline the means by which the alternate members of the delegation benefit by attending all meetings of the House, and how this resulted in benefit to the ISMS. While all delegates and alternate delegates have for many years been asked to attend specific reference committee meetings and report to the delegation at the next day's breakfast session, this past year the alternate delegates were requested to assume the responsibility of making the first and more detailed report to the delegation. Naturally, with the many meetings scheduled, the ability and knowledge of the full delegation (including the alternates) provides an opportunity to cover and study in detail more of the variety of material presented at both these sessions. The influence of 22 men is felt throughout the AMA House and some of the elections will bear witness to this fact.

At the New York meeting this coming July, Illinois will present the name of Walter C. Bornemeier as a candidate for the office of President-Elect. If he is a successful candidate (and at this time he has no opposition) he will be the first president from Illinois since Dr. Ernest E. Irons in 1949-1950.

Also, Illinois will nominate Burtis E. Montgomery to succeed himself as a member of the Board of Trustees for his second three year term. The fact that we plan to present two candidates makes the work of our entire delegation doubly important.

During 1968 only one alternate delegate was unable to attend a meeting. All of those present attended the working sessions of the delegation, and contributed materially.

All delegates and alternates were assigned and attended reference committee meetings. The alternate delegates made the initial report to the group, which was followed by a report given by the delegate assigned to any specific meeting.

The entire delegation went over all resolutions and all material in the handbook and reviewed in detail the reports to the House prior to the reference committee meetings.

The officers of the ISMS and any county medical society officers present, the delegates and alternate delegates from the sections who are members of the Illinois State Medical Society, and representatives of the Illinois Medical Service attended the meetings of the delegation and made significant contributions. This was also true of John Porterfield, Director of the Joint Commission for the Accreditation of Hospitals, who attended one of the delegate breakfasts.

At the last meeting of the delegation in Miami it was moved and adopted to welcome any past delegate who was in attendance at any future meeting of the AMA as a guest at all meetings of the delegation.

ISMS presented three resolutions at the San Francisco meeting, two of which were referred to the Board, and the third amended and adopted by House action. In Miami four resolutions were presented, three of which were amended and adopted and the fourth, by recommendation of the reference committee, was not approved.

New officers for the delegation were selected at the last meeting in Miami, and William K. Ford will head the delegation for the next two years; H. Close Hesselstine will serve as secretary.

As the socio-economic affairs of medicine become more and more complicated, the importance of the members of the delegation, both as delegate and as alternate, is easy to recognize. The men serving in this capacity are dedicated to the affairs of their society and are attempting to represent the 10,500 Illinois members carefully and efficiently. They ask cooperation, understanding and support.

Maurice M. Hoeltgen, *Chairman*

PRESIDENT OF THE WOMAN'S AUXILIARY

On our membership cards are these words: "Let the helping hands of the doctor's wife reflect and enrich his dedicated service." Our State theme this year has been "Make Membership More Meaningful." We hope that every doctor will encourage his wife to be an interested member of the Auxiliary in organized counties, or a member-at-large. Where there is no organized Auxiliary we hope the county medical society will help us get one started. In the new programs and projects there is something of interest for everyone.

We feel very strongly that personal contact is most important in telling our Auxiliary story. The National Convention, the Fall Conference for state presidents and presidents-elect, the Regional Workshop, plus the package programs, provide a wealth of ideas to help the state officers and chairmen. By talking at county and district meetings and having question and answer periods about these programs and projects, we hope that some of this knowledge and enthusiasm has been passed on to the county auxiliary members. *MD's WIFE, Direct Line* and *Pulse* also help us to reach every member.

Our National theme, "The Accent on Children and Youth," set the tone for our first Leadership Conference for Program Enrichment held this year in November. More than 60 enthusiastic Auxiliary members attended, representing 15 counties. The panelists were Mrs. Harlan English, past state and national president; Mrs. Paul E. Rauschenback, national chairman on children and youth; Mrs. Willard Scrivner and Mrs. Wendell Roller both of Illinois, national chairmen of Home Centered Health Care and Health Careers respectively; and Mrs. Thomas Tourlentes, state chairman of mental health. We also plan to have workshops and a film clinic at our **Convention**.

The county reports are not yet in to make a complete accounting of the year's accomplishments; this will be given in the report to the House of Delegates in May. However, you may be interested in knowing that we are continuing to contribute to AMA-ERF and to the Benevolence Fund. Our efforts are intensified in helping to relieve the health manpower shortage and in contributions to scholarships and loans for health careers.

Home-Centered Health Care has a new emphasis and programs are under study in several counties for meal services, volunteer friendly visitor training, and home-maker services.

International Health has a great appeal for Auxiliary members who collect drug samples, eye glasses, knit leper bandages, or make hospital coats and slippers, crib sheets, exercise balls, hygiene kits, layettes.

Although the national election is over, Auxiliary members need to be aware of new medical legislation and we urge them to join IMPAC and AMPAC. We hope to promote a visit to the state capitol to see our legislators in action.

Mental Health, Rural and Urban Health, Safety programs are all a part of Community Health and many new ideas are being developed in this area. State and county chairmen are asked to study the problems of their communities, and to work with other organized groups. At the request of the National President, Mrs. C. C. Long, we were urged to help in the campaign against violence on TV and movies.

Our Program Chairman sees that counties are kept up to date on the latest program materials available and how it can be ordered. Package programs include Teenage Venereal Disease, Youth Health and Fitness, Mental Health of Children, Health Careers, Immunization, The Block Mother Plan, Homemaker Service. The newest ones are on Sex Education, Drugs, and Alcohol.

We have been happy to have representation on the following Illinois State Medical Society committees: Aging, Cancer, Disaster Medical Care and Public Safety, Legislation, Mental Health, Public Affairs, Religion and Medicine, Scientific Assembly (Convention), Nursing, and Benevolence. We feel that we can coordinate our efforts with good results.

Because several county auxiliaries have disbanded and members-at-large are increasing (national trend), we made particular efforts this year to see that each member-at-large received information about auxiliary programs and projects. It is hoped that they will use some of these ideas in their communities working with other groups.

The Woman's Auxiliary to the Student American Medical Association has only one active group in Illinois. Their National Convention was to be in Chicago in April. Our state Auxiliary gave them a contribution and supported their activities.

We were pleased to be able to furnish to the Illinois State Medical Society 600 copies of Ann Lander's booklet "Sex Education and Family Life Guide" to be given to the Illinois Social Hygiene League. Also, we are co-operating with the Educational and Scientific Foundation to promote the Benefit Concert Series throughout the State.

We appreciate the help of the Advisory Committee in presenting to the ISMS Board of Trustees for consideration some needed recommendations for the guidance of Auxiliary affairs. We also appreciate the help of the executive administrator and his staff in providing services to the Auxiliary.

Mrs. Alden Rarick, *President*

Committees of the Board of Trustees

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The Advisory Committee to the Woman's Auxiliary met with the President and President-Elect of the Auxiliary on November 7, 1968. Following this meeting, a report was submitted to the Board of Trustees of the Illinois State Medical Society recommending the following:

I. ISMS Services To The Auxiliary

Under current operations, requests for services to the Auxiliary are received from many sources. This leads to confusion and a lack of control over costs. At the request of the Auxiliary representatives, the following has been developed:

- 1) All services performed by the State office for the Auxiliary should carry the approval of some one person, designated by the Auxiliary, to authorize these services, and subject to the approval of the Advisory Committee.
- 2) All requests for services should be channeled through the Executive Administrator's office to allow for proper coordination and to assure that deadlines for producing the work will be met.
- 3) Services will be provided only for projects of the Woman's Auxiliary to the Illinois State Medical Society, not projects sponsored by a County Auxiliary or the AMA Auxiliary.
- 4) The Society's out-of-pocket expense for services will be charged to the Auxiliary allocation. Any additional services will be provided within the limits of available staff time and at the expense of the Auxiliary.

II. Secretarial Services for the Auxiliary

The Committee feels that the program would be improved if the Auxiliary employed a part-time secretary to serve the Auxiliary. Working space and supervision of this employee would be provided by ISMS. The following recommendations have been made:

- 1) That a pilot project for providing secretarial service be established, using Auxiliary reserve funds to initiate the project.
- 2) That the annual Auxiliary dues be increased to \$10.00 to finance secretarial services on an on-going basis.
- 3) That a priority listing of Auxiliary projects be established.

III. Membership

The Auxiliary was again urged to change the membership and fiscal year to correspond to that of the ISMS, January 1 to December 31. The County Medical Societies have been advised of the provision for joint billing of Auxiliary dues with medical society dues. Dues remitted to ISMS under the joint billing will be paid directly to the Auxiliary rather than returned to the County Society as heretofore.

IV. White House Conference on Children

By invitation, the Auxiliary is represented on the statewide coordinating committee for planning the forthcoming White House Conference on Children.

At the request of the Auxiliary representatives, the following positions on several national issues involving children have been made:

- 1) To oppose the inclusion of children under a Federal Health Insurance Plan.

- 2) To oppose free college education for children at taxpayer's expense.
- 3) To support the broadening of programs on sex education in principle, but to examine specific suggestions from the standpoint of practical application.

V. Annual Meeting Conflict

The Auxiliary sponsored nightclub tour during the Annual meeting conflicts with other scheduled events, particularly the Public Affairs Dinner. Some members of the Auxiliary feel this conflict should be avoided. The Committee has recommended that no Auxiliary function be held which conflicts with the ISMS program (Public Affairs, President's Dinner, etc.).

All of the above recommendations were approved by the Board of Trustees and transmitted to the Woman's Auxiliary of the Illinois State Medical Society. The Committee commends the officers and members of the Woman's Auxiliary for their continued effort to support the policies and programs of the Illinois State Medical Society.

Edward W. Cannady, *Chairman*
Frank J. Jirka, Jr. Philip Thomsen

ARCHIVES COMMITTEE

No report.

Leo Zimmerman, *Chairman*
Everett P. Coleman Emmet F. Pearson
H. Kenneth Scatliff

COMMITTEE ON COMMITTEES

Experience and time are revealing a number of areas of inefficiency and some confusion in our Council and Committee structure, as adopted by the House of Delegates in 1967 and amended in 1968.

Your Committee on Committees met and on July 20, 1968, reported to the Board of Trustees, our deliberations on suggested areas as follows:

- 1) There is obvious conflict of interest between the Judicial Council and the Ethical Relations Committee. *It was recommended to the Board that the By-laws be changed, removing the Judicial Council. This change was approved by the Board of Trustees.*
- 2) It was recommended and approved that a Medico-Legal Council be established with committees on Impartial Medical Testimony, Licensure and Quackery, and Laboratory Evaluation.
- 3) It was recommended and approved that the Committee on Public Health be broadened and the subcommittees on Occupational Health, Environmental Health, and Tuberculosis Control be abolished, and Cancer Control be made a full committee.
- 4) It was discovered that the Council on Public Relations also had a Committee on Public Relations. It was recommended and approved this be changed to "Public Liaison Committee." The Advisory Committee to Para-Medical Groups to be broadened to include Advisory to Medical Assistants, Advisory to SAMA and Advisory to Health Careers Council. Also that the name be altered to Advisory Com-

mittee to Interprofessional Groups. The Nursing Committee and Public Safety Committee be made full committees.

- 5) Under the Council on Medical Service an Advisory Committee to the Department of Vocational Rehabilitation has been provided, similar to that to the Illinois Department of Public Aid.

No doubt there are and will be other areas noteworthy of review from time to time. While we must be pragmatic—we do not wish to appear opinionated, and do welcome suggestions from the staff and all members of ISMS.

Darrell H. Trumpe, *Chairman*

James B. Hartney

Charles K. Wells

Warren W. Young

COMMITTEE ON CONSTITUTION & BYLAWS

At the time this report was prepared, nothing had been referred to the Committee on Constitution and Bylaws for consideration except the one request on which action was not taken last year—that the name of the Journal Committee be changed to "Publications Committee."

The correct changes will be made in the Bylaws if this meets with the approval of the House.

If other material is received, a supplementary report will be prepared for presentation to the opening session of the House on Sunday.

Andrew J. Brislen, *Chairman*

THE EDUCATIONAL & SCIENTIFIC FOUNDATION

The Educational & Scientific Foundation of the Illinois State Medical Society was established in 1961. The Foundation is incorporated in Illinois and financial support is tax deductible. The Foundation is dedicated to the advancement of medical knowledge and the education of the public, particularly in the State of Illinois. The Foundation is managed by a Board of Directors which consists of the ISMS President, the immediate Past-President, the Secretary-Treasurer and the Chairman of the Board of Trustees. The immediate Past-President serves as Chairman of the Foundation Board and the Secretary-Treasurer of the Society occupies the same post in the Foundation. There are three classes of membership in the Foundation:

- 1) Fellows of the Foundation are physicians holding regular membership in the Foundation following the contribution of \$100 or more.
- 2) Associate fellows are non-physicians holding regular membership in the Foundation following a contribution of \$100 or more.
- 3) Honorary fellows are individuals whom the Foundation's Board of Directors elect to membership because of their exceptional service to the organization and its goals.

Members of the Illinois State Medical Society can be justly proud of their Foundation in the many projects sponsored to date. The Board of Directors would like to embark on a program of help to medical students, particularly in the program that assigns students to physicians within the state on preceptorship. We would earnestly urge members of the Illinois State Medical Society to consider the solicitation of funds for the Educational & Scientific Foundation.

Toward this end the Foundation is offering a two-piano concert to county medical societies and auxiliaries who are willing to co-sponsor the event as a fund-raising project in their communities.

Performed by a Kankakee doctor's wife and her partner, both professional musicians, the concert is an interesting musical evening for a good cause. The first in the series was scheduled to be performed April 12 in Kankakee.

The Foundation also serves as a receiving and disbursing agent for a \$5,000 grant from Merck Sharp & Dohme to operate the Scientific Speakers' Bureau.

Following is a list of county medical societies using the service in 1968, the number of meetings using bureau speakers and the number of physicians who spoke at these meetings.

Bureau County—11 meetings, 11 physicians
Champaign County—3 meetings, 3 physicians
Coles-Cumberland County—1 meeting, 1 physician
DeKalb County—5 meetings, 7 physicians
Greene County—2 meetings, 2 physicians
Henry County—5 meetings, 5 physicians
Kane County—4 meetings, 4 physicians
Knox County—4 meetings, 4 physicians
LaSalle County—9 meetings, 8 physicians
Lee County—1 meeting, 1 physician
Livingston County—4 meetings, 4 physicians
Macoupin County—1 meeting, 1 physician
McDonough County—1 meeting, 1 physician
Montgomery County—2 meetings, 2 physicians
Rock Island County—1 meeting, 1 physician
CMS/Southern Branch—2 meetings, 2 physicians
Vermilion County—2 meetings, 2 physicians
Whiteside County—10 meetings, 10 physicians
Williamson County—1 meeting, 1 physician

During 1968, the following became Fellows of the Foundation: Warren W. Young, M.D., W. A. McNichols, M.D., and Casper Epstein, M.D. The directors also gratefully acknowledge a contribution of \$100 from Michael R. Saxon, M.D.

Newton DuPuy, *Chairman*

Philip G. Thomsen

Frank J. Jirka, Jr.

Jacob E. Reisch

COMMITTEE ON OSTEOPATHIC PROBLEMS

Your Committee on Osteopathic Problems has reviewed information on this subject as it became available during the past year. Actions taken by the AMA and by other states were studied and discussed. Correspondence received from various members of the Society was reviewed and scrutinized. On the basis of all information received and a thorough discussion of the same among members of the Committee and with other members of the Society and in view of the trends exhibited by other states and the AMA, the following recommendations were made to and approved by the Board of Trustees at its January 11-12 meeting:

1. *Whereas Doctors of Osteopathy, qualified by education, now take the same exam as do physicians, and
Whereas these Doctors of Osteopathy, if they pass this exam, are then qualified to practice medicine and surgery in all of its branches in Illinois, and
Whereas the Bylaws of ISMS do not prohibit membership by a qualified and fully licensed Doctor of Osteopathy, and*

Whereas in recent action, the AMA suggests that each county and state medical society may accept qualified Doctors of Osteopathy as active members, now therefore be it

Resolved that your Committee recommends that an appropriate resolution to accomplish this be prepared and submitted for consideration of the next House of Delegates, with the question of membership eligibility to be determined on an individual basis at the local level.

2. A proposed plan of the Health Careers Council of Illinois to grant membership to the Illinois Osteopathic Association was presented and discussed. In view of the foregoing recommendation, as well as the recent December 1-4, 1968, action of the AMA House of Delegates, the following motion was unanimously adopted by your Committee:

"That since the AMA recognizes no difference between the Doctor of Medicine and the Doctor of Osteopathy who is fully licensed, there is no reason why both ISMS and the Illinois Osteopathic Association should be represented on H.C.C.I."

3. In furtherance of the policy adopted by the 1968 ISMS House of Delegates on the relationship with Doctors of Osteopathy, the following recommendation is made:

"That those Doctors of Osteopathy who are licensed to practice medicine in all its branches in Illinois be invited to attend the 1969 Annual Meeting of ISMS."

William E. Adams, Chairman

Arthur F. Goodyear

Charles K. Wells

Paul P. Youngberg

POLICY COMMITTEE

The Policy Committee of the Board of Trustees has received both oral and written inquiries regarding a number of problems during the past year. Its members have investigated various areas about which inquiries have been made and will have recommendations for the House to consider as additional Policy Statements.

The specific material on which the Policy Committee was asked to report is as follows:

REBATES

1) "In conformity with the AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical." This statement on rebates was developed as a result of a letter regarding collection services. It read in part:

"It is our policy to remit to a participating association the sum of 10 per cent of the gross book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

PUBLIC HEALTH DEPARTMENTS

2) After considering AMA Policy (statements from 1948, 1962 and 1964 supplied by consultation with AMA library), together with suggestions received from Dr. Franklin D. Yoder, Director, State Department of Public Health, the committee submits for your consideration the following statement:

"Public Health is the art and science of maintaining, protecting and improving the health of the

people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

"Full-time modern local Health Departments adequately financed and staffed at the county or multiple county level are highly desirable, and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support."

These two items constitute the report of the Committee on Policy to the 1969 House of Delegates.

A complete review of the manual will be made by the committee at its meeting on March 8, and if a supplementary report is deemed necessary, it will be submitted.

William E. Adams, Chairman

Arthur F. Goodyear

Paul P. Youngberg

PUBLICATIONS COMMITTEE

While the year 1968 was not what might be termed "dramatic" as far as any single aspect of the *Illinois Medical Journal* is concerned, steady growth and progress, refinement and improvement were the keystones of Committee concern. A distinct desire to serve the needs of the membership permeated all considerations. The Publications Committee, meeting often during the year, considered many policy and procedural items. A prime objective, and a continuing consideration, was improvement of the *IMJ*. Several new items were introduced and a review of continuing features was maintained.

The Committee established guidelines for typographical refinement, including the use of varying headline styles, a sans serif type face for excerpts, greater employment of "white space," and the use of tint block pages or tinted stock for special feature sections. These refinements were instituted on a gradual basis and are at this writing nearly completely effected. Over a trial period of several months, varying types of covers were developed. Through this means it was hoped to make the *IMJ* a more attractive magazine, immediately catching the eye of the subscriber. This effort seems to have been successful. Other refinements dating back to the Opinion Research Survey findings pertaining to the *Journal* have also been implemented with a view to making the *IMJ* a magazine which each member will respect and one which will satisfy his needs, insofar as such may be accomplished by a state journal.

Several new continuing features and special articles were instituted during 1968. Among these were: "Membership Forum," a means whereby the Illinois practitioner may air his views on any subject or may comment on items appearing in the *Journal*; "IDPA—Payments Policies and Procedures Explained," a continuing series presented through the offices of the Department of Public Aid, with an aim to assist the practitioner with processing IDPA bills and to build rapport between physicians and the department; "Medical Legal Problems," articles prepared from time to time by ISMS' Legal Counsel explaining the ramifications of particular points of law as such apply to the Illinois medical practitioner; "Practice Management News," a new feature in early 1969 which is intended to assist in office management; "Public Affairs Reviews," another series, new in early 1969, to assist physicians in obtaining educa-

tional materials in the area of public affairs; "Rx Cross Reference," begun in January, 1969, as a secondary product index to which the physician may refer each month to easily find the page advertising a particular product; "Your Insurance Questions," a monthly "quickly" on a particular question in the field of insurance or investment.

In addition, an expanded coverage of "Abstracts of Board Actions" ensured every ISMS member the opportunity to be better informed of the actions of the Board of Trustees. Expansion, also, of the Meeting Memos item served to alert physicians to continuing education opportunities.

These "organization items" occupied approximately 19 pages of each issue, on the average, and balanced in very nicely with a 40% advertising, 40% clinical articles, 20% organizational items ratio over the year.

By and large, the articles carried in the *Journal* were of excellent caliber, as was attested by the fact that in several instances articles were picked up by wire services or were the basis for a story by a large daily. The largest *IMJ* ever produced was the October Reference Issue. Consisting of 252 pages, it presented a most comprehensive listing of ISMS activities as well as ancillary educational and governmental activities.

A series of articles on Medicine and Religion has been a regular feature of the *Journal*. These are published through the auspices of the ISMS Committee on Religion and Medicine. A brochure incorporating 12 of these articles dealing with "What Every Doctor Should Know About the Religious Needs of His Patient" was published during the year. This brochure, with a printing of some 16,000, was distributed to all nursing stations in all hospitals, to every chaplain's office, and to all hospital administrators in Illinois. Initial acceptance was great and the continued requests for additional copies indicate the worthiness of the publication. To the best of the Committee's knowledge, no other state medical society has produced anything of this nature.

During the year, a membership survey, authorized by the Board of Trustees, was conducted by the Council and Committee on Public Relations. The results of this survey formed the basis of a series of three articles in the *Journal*. The survey afforded insight into the membership's attitude in medical-legal, socioeconomic and practice matters. Requests for the results of the survey have been received from all over the country. The *Journal* benefited by being able to relay to the entire membership indications of how Illinois medical practitioners felt about current issues.

During the year, as in the past, the question of publication of papers presented at a symposium was discussed. In an effort to establish a basic guide, the Committee adopted the following policy for the *IMJ*:

"In the publication of symposia, these may be published in (a single issue of) the *IMJ* only after review and recommendation of the Editorial Board and approval by the Editor. Special consideration should be given such publication, however, if additional financing (arranged by the sponsoring committee) is available to cover the publication cost.

"Committee chairmen should not commit the *Journal* to publication of special papers or symposia without prior consultation with the Editor."

This policy would in no way preclude publication of some or all of such papers, especially on a serialized basis. However, the devoting of one or two entire issues to papers from one meeting or on one topic would be detrimental to the balance of the *Journal* and would

satisfy the readership desires of only a small minority.

In 1967 the membership lists of ISMS were placed on computer tapes. This has proved to be a boon in handling many matters. Mailings have been sent out with greater efficiency and the rate of returns has dropped to a mere trickle, less than 1/3 of 1%. And this is improving every month as the files are updated with greater speed.

A proposal from University Microfilms, Inc., a subsidiary of Xerox Corporation, located at Ann Arbor, Michigan, was studied and approved after thorough review by the Committee and Legal Counsel. At no expense to the Society, each issue of the *IMJ* is microfilmed and placed in storage. Upon request, any person may purchase a print of any particular issue or portion of an issue. Copies would be sold at a nominal sum and ISMS would receive a 15% royalty.

Advertising revenues fell slightly during 1968. From \$101,000 in 1966, receipts rose to a record high \$149,000 in 1967. The total for 1968 was off some 10%, to \$134,656. The decrease is due to many factors. Prime among these are the restrictive policies of the FDA on pharmaceutical advertising. While safeguards are necessary, the drug companies were not able to adjust quickly enough to change all ad copy. As a result, *IMJ*, as well as other state journals and *JAMA*, suffered a decline. However, the decline for *IMJ* was not as great as that experienced by many other state journals, due to our access to advertising agencies and to the expertise of our advertising representatives. Unfortunately, as of the time of this report, 1969 looks no more promising than 1968. The initial changeover in Washington and in the Department of HEW, a slowing of the economy due to additional taxation, a feeling of uncertainty due to activities in foreign countries—all contributed to a first quarter roughly equal to the same period in 1968. Additional comments on efforts to offset this are to come later in this report.

The Internal Revenue Service ruling that a 48% tax must be paid on non-related income of associations such as ISMS, unilaterally imposed by the IRS, was to be applied against 1968 income of the *Journal*. Under this ruling the *IMJ*, after a \$1,000 deduction, would be liable for 48% of its net income. The ruling was contested several times during the year and various attempts to change it were made in the U.S. Congress. In fact, the Senate passed a rider to a bill which would exempt certain agencies, but it died in the House. As of this writing, the House Ways and Means Committee is holding hearings on the matter. However, a personal discussion with some members of Congress on the deletion of this tax was far from encouraging. Steps taken in 1968 to be prepared for the application of the tax included a better cost accounting system for the *Journal* and the listing of all production and overhead costs for the *Journal* which heretofore had been absorbed in general operating expense of the Society. Through this means a true picture of net revenue will be achieved. Needless to say, such will be quite low since the margin on which the *Journal* operates, particularly as a non-profit organization's publication, is extremely low.

With the outlook for increased advertising revenue in 1969 being low, steps have been taken to compensate. The Chairman of this Committee, the Director of Business Services of ISMS staff, the *Journal* advertising manager and the eastern sales representative are all doing their utmost to continue to gain entry to pharmaceutical

houses and ad agencies to extol the merits of advertising in the *IMJ*. Some successes are noted in the effort and a continuation throughout 1969 will hopefully result in a revenue increase sufficient to keep the *IMJ* from incurring a devastating deficit. The aforementioned individuals have met and talked with media buyers and representatives in New York, Philadelphia, Detroit, Indianapolis and Chicago and further activity is planned.

"Pulse"

The monthly periodical, *Pulse*, continued through 1968 into 1969 in good fashion. A much read, widely distributed newsletter type publication, its greatest asset is its versatility. With two pages devoted to advertising and two pages for the news of the Woman's Auxiliary, four pages are given to reports on featured events of ISMS, to recognize honors and accomplishments of ISMS members, and to alert physicians to important items. The materials presented are most eclectic and the Illinois practitioner has responded favorably in his acceptance of this news media. This Committee expresses its sincere appreciation to Roche Laboratories for its continued sponsorship of the publication.

"What Goes On . . . in Illinois"

During 1968, *What Goes On* appeared in a new format, with improved typography and layout. The content materials were most important and the publication filled a definite need for the busy, practicing physician by alerting him to significant meetings in continuing education. Lederle Laboratories is thanked for sponsoring this periodical which appeared nine times. Many agencies and societies contributed news of their meetings to be listed and an ever increasing amount of detail appeared.

Unfortunately, the beginning of 1969 witnessed the demise of *WGO*. For economic reasons the subsidy for the publication had to be withdrawn. After repeated attempts by your Committee and staff to interest another pharmaceutical house to pick up the publication costs failed, *WGO* went out of print. It is hoped that future efforts to revive it will be successful. In the meantime, expanded coverage of meeting announcements are being carried in both *Pulse* and the *Journal*.

Staff Organization

After considerable discussion and orientation, the Publications Committee recommended that the former Division of Publications and Scientific Services be split into two divisions—one serving publications and the other scientific services. This recommendation was approved by the Executive Committee and the Board of Trustees early in 1968. Thus, the Division of Publications was established with responsibility for all editorial and production functions of ISMS, and to assist all divisions in the production of their printed materials. The editorial functions (exclusive of clinical material) include contents, general makeup, typography, layout, design, style and format, as recommended and approved by and through the Publications Committee.

Responsibility for advertising sales was assigned to the Business Services Division and while the actual production work and responsibility for getting the *Journal* out rests in the Publications Division, some additional work in this area is necessary through staff in the Business Services Division.

Thank You

The Committee is indebted to the many persons who assisted in the work of publications and to the various ISMS and Board Committees which gave of their time and counsel in the work of this Committee.

Thanks are due Mr. Perry Smithers, who, after several years affiliation with publications and the *Journal*, took over the helm of the Division of Education and Scientific Services. We are also most appreciative of the work of Mr. John Kinney who has recuperated from the illness suffered in late 1966, and has now returned to full production as Advertising Manager. Mr. Roland King, Director of Business Services, has devoted extensive time to the improvement of computer services as applied to publications and has also extended significant effort in the acquiring of additional advertising accounts. The addition of Miss Lauren Bateman to the Publications Division staff in August allowed for expanded operations of the Division with a greater degree of efficiency. Mr. Richard Ott, as Director of Publications and Managing Editor, has accomplished many refinements and improvements in ISMS communications and is to be commended for his interest and willingness to devote extra time and effort to produce a journal with individuality and newness. Accolades are also due Dr. Van Dellen, *IMJ* Editor, and the many persons adding to the excellence of our publication.

Jacob E. Reisch, *Chairman*

J. Ernest Breed

Darrell H. Trumpe

Warren W. Young

Editorial Board

The Editorial Board of the *Illinois Medical Journal* met September 26, 1968.

Dr. Van Dellen, the Editor, reported on the substantial back log of manuscripts awaiting disposition in his office. He also mentioned that several groups of papers from symposia increased the amounts of this back log material. Several manuscripts were submitted to members of the Editorial Board for advisement. One of these for technical reasons was not acceptable. The publication of the symposium papers at this time is impossible because of the volume of manuscripts.

The Editorial Board recommended that the Board of Trustees advise committees programming symposia to not guarantee publication in the *Journal* if papers were submitted before consultation with the Editor. Papers now with the Editor will be returned to the appropriate committees. These could be published in a supplement if the cost of publication were arranged.

The serial articles submitted by the Illinois Heart Association were not accepted because of the requirements for space. Various suggestions were discussed as means to dispose of accumulated manuscripts. The Board reaffirmed that the distribution rates of the *Journal* should remain at 40% advertising, 40% clinical and 20% organizational. Consideration was given also to the position of summaries, the use of cartoons, and the content material of the *Journal*.

Edwin F. Hirsch, *Chairman*

James H. Hutton

C. J. Mueller

Samuel A. Levinson

Frederick Steigman

Charles Mrazek

Frederick Stenn

Arkell M. Vaughn

EDITOR ILLINOIS MEDICAL JOURNAL

During the preceding year the *Journal* was made up of 1,608 pages. Of these, 644, or 40 per cent, were used for advertising, which is exactly in line with the 60/40 breakdown under which we operate.

This left 964 pages for editorial material. Of these, 309 of the pages were clinical (including the View Box); 48.75 were on the History of Medicine; 102 were special features; 10 were book reviews; and 14.5 were editorials.

If I exclude the 250 pages of the reference issue from the editorial space, we are left with 225 pages that were devoted to organizational material which averaged 18 pages per month. This is also in accordance with established guide lines.

This year we lost the services of Perry Smithers who left to become the director of the educational and scientific services. He was replaced by Richard A. Ott. Caroline Boeckman also resigned. She spent many hours preparing our index.

May I also take this opportunity to thank John A. Kinney, our advertising manager; Dr. John M. Beal, of Surgical Grand Rounds; Dr. Leon Love, editor of the View Box; Dr. Harvey Kravitz, our medical progress editor; and all those who contributed book reviews.

T. R. Van Dellen, *Editor*

COMMITTEE ON USUAL AND CUSTOMARY FEES

During the past year, the committee concerned itself with the continuing problems of the usual and customary fee program of the Illinois Department of Public Aid.

Under this program, IDPA is committed to pay usual, customary and reasonable fees for medical procedures to public aid patients.

During the first 18 months of the IDPA-ISMS Usual and Customary Fee agreement—from January, 1967 to July, 1968—physicians were extremely critical of the program, claiming they were receiving only partial payments on their billings. In fact, a July, 1968, survey showed that 67 percent of the participating physicians were dissatisfied with their IDPA payments.

IDPA reported that most of the dissatisfaction emanated—not from its payments for medical procedures—but from its “cost plus 20 percent” payment on dispensed drugs and injectables. Physicians who do not specify the drugs used are paid only \$1.00 for the drug, resulting in numerous complaints.

After July, 1968, however, complaints against IDPA's payment procedures declined sharply. The committee attributes this to three important programs:

- 1) A series of 13 ISMS Workshops on Government Health Programs conducted throughout the state to help physicians obtain prompt and accurate payments from IDPA, Medicare, etc.
- 2) A series of *IMJ* feature articles keeping physicians informed of IDPA payment policies and procedures.
- 3) Newly-developed IDPA fee profiles. By October, 1968, IDPA had accumulated sufficient data to compile individual fee profiles on all participating physicians, thus allowing the department to more accurately meet physician billings. All current IDPA payments are now based on these individual profiles.

The Committee's biggest problem arose when IDPA requested approval of a controversial agreement requiring the signature of all participating MDs beginning January 1, 1969. (Signed agreements by providers of

services are necessary if Illinois is to continue receiving matching funds from the federal government under Title 19 of the Medicare Law.)

While ISMS could not oppose the agreement—since it is stipulated in a 1967 amendment to the Federal Social Security Act—it did succeed in having most of the objectionable parts eliminated. The revised, ISMS-approved version—as opposed to the original nine-part agreement—stipulates only that:

- a) The physician agrees to keep such records as are necessary fully to disclose the extent of services provided to individuals receiving assistance and to furnish the Department with such pertinent and reasonable information regarding payments claimed as the Department may from time to time request.
- b) The agreement may be terminated by the physician or the department at any time upon written notice.

The committee and Board of Trustees also approved a “test” plan proposed by Clark County physicians who object to “accepting assignment” in Medicare/Medicaid cases. The plan calls for a uniform arrangement whereby IDPA would pay the first \$50 of each patient's annual bill under Medicare standards . . . the carrier would pay 80 percent of the remainder . . . the MD would absorb the final 20 percent . . . and no “assignment” of unpaid bills would be necessary.

Should the pilot program prove successful, IDPA would consider expanding it to other counties. At the time of this report, however, no progress report has been made.

The most unfortunate problem hampering the IDPA program is the insufficient number of participating physicians, especially in the Chicago area. It is estimated that less than 100 physicians are handling almost half of the Public Aid patient load for the entire state. Unless we can convince more physicians to accept Public Aid patients, this program may be in serious trouble.

In conclusion, the committee urges all county medical societies to establish an Advisory Committee to counsel the County Public Aid Department and a Fee Review Committee to act on complaints between IDPA and local physicians. Only when a problem cannot be solved on the local level should it be referred to the State Medical Society for review.

Joseph R. O'Donnell, *Chairman*

W. C. Scrivner

J. Mather Pfeifferberger

James B. Hartney

Joseph L. Bordenave

VISIT YOUR EXHIBITS

Sherman House Hotel

Technical Exhibits—
Mezzanine Floor

HOURS

Monday, May 19—
11:00 a.m. to 5:00 p.m.
Tuesday, May 20—
9:00 a.m. to 5 p.m.
Wednesday, May 21
9:00 a.m. to 5:00 p.m.

FINANCES & BUDGETS



SECRETARY-TREASURER

It was exactly ten years ago, on March 8, 1959, that the Council (now Board of Trustees) of the Illinois State Medical Society authorized a special management study by Roscoe Edlund of Rogers, Slade & Hill. Most of the changes and recommendations made in this report have been implemented, resulting in increased service to the membership and more effective accomplishment of the Society's objectives. Now, in 1969, a management study of the organization and management of medicine's esteemed flagship—the American Medical Association—is receiving front page news space and attention. The recognition of the need for analysis is certainly the better part of improvement. In 1959, the leaders of the State Medical Society were aware of the need for analysis, just as the Trustees of the AMA are aware that, today, there is a need for more effective methods and management to satisfy medicine's needs. Changes made today, however, must also lay the groundwork for many tomorrows, but evolution should be the procedure, not revolution in a rash search for instant perfection.

I believe that it was Adlai Stevenson who observed wryly that the words "We live in a world of change" were first spoken by Adam. Medical organizations must always be capable of adapting to the changing environment which surrounds them. Achievement of the Society's chartered objectives effectively, expeditiously and economically was the goal set out by Rogers, Slade & Hill in 1959 and it continues as the Society's goal in the drastically changed world of 1969. In the accomplishment of this there is one key factor—for the AMA as well as for ISMS—the support and assistance of all members, and an opportunity for them to speak and be heard. Constructive criticism is the nucleus of progress and improvement.

House of Delegates Minutes

Once each year, representatives of each physician in the state come together to form the House of Delegates of the Illinois State Medical Society. In this forum, the views of all are open for communication and judgment. Past actions and future directions are studied with diligence and intelligence. Ideas and feelings are here translated into printed words, becoming the minutes of the actions taken, and are recorded for future reference and guidance.

To insure accuracy in interpreting the decisions and actions of the House, a complete stenographic record of each session is obtained. As Secretary-Treasurer of the Society, I have reviewed this transcript to verify its ac-

curacy and completeness. Any Society member who also wishes to review this record is invited to do so and should make his request known to the Secretary-Treasurer or Executive Administrator. You may be interested in noting that the 1968 transcript consisted of 359 pages, 1967 ran 450 pages, and 1966 totaled 439 pages. Evidently, in 1968, a rising trend in the direction of the spoken word was reversed.

In order to make the major actions of the 1968 House quickly available to all members, a resume was mailed to each delegate within one week after the meeting. This enabled delegates to report promptly and accurately to their local societies. The July, 1968, issue of the *Illinois Medical Journal* contained an abstract of the transcript for the benefit of each member.

As in the past, the abstract form of the 1968 minutes will be presented to the 1969 House of Delegates for approval.

Membership Records System

If imitation is any form of flattery, then ISMS should be pleased that the direct dues billing and collection system available to Illinois county societies since 1966 has now gone "national" with the introduction of a package called CAPIS and sponsored by the AMA-approved East Coast mailing house of Fisher-Stevens. Although not as inclusive as the ISMS computer-based physician biographic record system, CAPIS points out the obvious need to provide new and better centralized services for those county societies that are not large enough to have a lay staff.

Following the fall, 1967, conversion of the Society's biographic IBM records from punch cards to magnetic tape, the 1968 direct dues billing and collection system performed admirably, yielding a great number of accurate and varied dues payment reports on a well-scheduled basis. Each year has seen improvements in this system, both in accuracy and on a time saving basis.

The computer programs generate many sets of membership address labels each month, and the use of a carbon technique provides multiple copies at an extremely low cost per label. Labor costs in this area of Society activity have been materially reduced by this new method. Again, I must repeat that the Society *has not* purchased, leased or rented a computer or other data processing equipment of any kind. It *has* prepared a master tape file, which is the property of the Society, and which can be used on any of the latest makes of com-

puters now in general use. As the need arises, computer time is rented to accomplish a project. If and when the need arises, much more information can be placed on this tape, the only cost being that of the necessary programming.

In addition to the above, rosters of members are prepared periodically in a variety of formats for internal reference, enabling staff to perform a myriad of assignments not possible prior to the introduction of this system.

One example of the potential uses for the ISMS Computer facility was the Socio-Economic Issues Survey conducted in late 1968. The survey was conceived and designed by the Public Relations Division; programmed, conducted and tabulated by the Business Services Division; interpreted by the Public Relations staff; and publicized by the Publications Division. Thus, a unique project was carried through from start to finish by ISMS staff, serving as a current reminder of the specialized and complete nature of their abilities and the tape's capabilities.

Communication with Members

Realizing the essentiality of communications with the membership and recognizing that communications must be a two-way freeway if results are to be obtained, all divisions of the Society have sought to increase their contacts and develop closer liaison with the members during 1968. This has been accomplished in several ways, such as the President's Tours, workshops, district meetings and the printed word.

A new "Membership Forum" was introduced in the November, 1968, issue of the *Illinois Medical Journal*. Any member who has an idea or belief or gripe (or, hopefully, praise) for any aspect of the organization and delivery of administrative service or official leadership can utilize this page to bring his views before a wide public audience. Addition of the Membership Forum brings to five the number of standing invitations to respond found in different sections of each monthly *Journal*. If an individual physician considers his views on the Society's actions important, he should communicate these opinions to the Society's leadership and his fellow members. A responsive democratic society cannot exist without this concerned involvement and a better ISMS will be developed with such membership interest.

The previously mentioned Socio-Economic Issues Survey of all members, conducted by the Society in mid-1968, gave the Society's leadership a basis for presenting the membership's opinion on several vital issues currently affecting the practice of medicine. Legislative and legal topics, socio-economic subjects and professional practice issues were covered. The November, 1968-January, 1969 *Illinois Medical Journals* reported and evaluated the answers given—and the action to be taken. This was a unique experience in open communications between individual members and current officers and staff, and all members who cooperated in the survey are to be sincerely thanked. As stated by Matthew B. Eisele, M.D., chairman of the Committee on Public Relations: "Your opinions have given ISMS a keener sense of direction . . . they have stirred the breezes and currents . . . and your leaders are sailing forward."

It is most unfortunate that the Society has been forced to terminate publication of one of its newer and informative communications—the monthly calendar of medical events "*What Goes On*." Lederle Laboratories, sponsor of this publication for several years, was unable to con-

tinue this support for 1969. Since January, 1966, this publication has been the only "one-stop" source of information to all Illinois physicians regarding all meetings of a medical nature. It is especially significant that the oft-mentioned "gap" between knowledge available and its dissemination to the practitioner cannot be properly bridged without a communications tool such as "*What Goes On*." Society staff and officers will continue to seek full or partial sponsorship for the costs of this line of communication, and are hopeful that medical school and local health agency cooperation to this end may be achieved.

In November, 1968, another communication line was established when the *Journal* published the first in a continuing series of articles concerning Illinois Department of Public Aid methods, procedures and policies. The intent of the articles was to speed up payment of physicians' bills by pointing out what information is essential on the billing forms to enable the computer to handle them. Physicians' questions regarding Department operation were and are solicited and will be answered either by direct communication or in the articles themselves.

Condolence Letters

Early in 1968 a new recognition of ISMS membership was instituted by sending an individually typed and personally signed letter of condolence, properly worded to fit the occasion, to the families of all deceased members. Many have been the gracious and appreciative replies received from these expressions of sympathy.

Leadership Conference

Physicians from all over the state met in Springfield on Sunday, October 6, 1968, to attend the annual Leadership Conference. Tragic circumstances surrounding the death of Martin Luther King forced postponement of the original conference scheduled for April 7, but the closeness to the 1968 election served to enhance the value of the re-scheduled event.

A regular meeting of the ISMS Board of Trustees was held on Saturday, preceding the Leadership Conference, affording the members of Sangamon County and the Fifth District an opportunity to "sit-in" on a Board meeting and observe the many items discussed and acted upon on their behalf. Interspersed between Board sessions was a dinner for the Trustees at which the first ISMS Religion and Medicine Award winners were honored. These were the first such awards ever presented in the United States.

Among the conference speakers were U.S. Senator Everett M. Dirksen; Dr. Dwight L. Wilbur, San Francisco, President of the American Medical Association; ISMS President Philip G. Thomsen; Washington political columnist Robert Novak; and a panel made up of Illinois Congressmen Findley, Rumsfeld and Shipley. Many ISMS and State of Illinois officials also participated in the day's program which covered the areas of Comprehensive Health Planning, Health Manpower, 1968 Presidential Election Prospects and Current Legislative Activities.

As might be anticipated, this outstanding program drew the heaviest attendance of any past Leadership or Secretaries' Conference. The significance of this is perhaps the key to the success of any meeting—a good audience will be had when an attractive program made up of high caliber participants speaking on current subjects of interest is made available. While this meeting is

designed primarily for county society officers, delegates and members of the Legislative and Public Affairs Committees, all members of the Society are urged to attend. State and county Woman's Auxiliary officials also meet in conjunction with this and other ISMS meetings, and physicians' wives are invited to attend these sessions to see their Auxiliary officers in action.

Society's Tax Status

A year ago a report was made concerning the then impending IRS ruling of a 48% tax on "unrelated income" of associations such as ISMS. This, in the Society's case, would apply to the net income from the *Illinois Medical Journal*. This regulation was upheld during the 1968 session of Congress, despite valiant efforts by Senate Minority leader Everett Dirksen of Illinois to defer this change until further Congressional investigation. The first tax return under the new terms will be filed for 1968 by May 15, 1969. It is expected that deductible expenses of publication will equal or slightly exceed advertising and subscription revenues, resulting in no income tax liability.

The House Ways and Means Committee hearings on tax reform, scheduled for February and March, 1969,

heard AMA testimony that the Internal Revenue Service exceeded its authority by attempting to tax advertising revenues of tax-exempt organizations. It was brought out that legitimate activities carried on in furtherance of exempt purposes should be protected from erosion through arbitrary bureaucratic fiat, since the revenue amendment under which this regulation was established was enacted 19 years ago (1950) by Congress.

It is unfortunate that a matter so crucial to non-profit association existence is mixed together with the general public's discussion of charitable foundations and other "loophole" styled deductions. When Congress originally granted tax exemptions, it decided correctly that private action serves the public interest. If legislators (and all tax-exempt organizations) continue to act responsibly, that decision will continue to hold good for the future.

Variations in *IMJ* advertising income, increasing production costs, and the possible tax liability make it most difficult to project the 1969 financial status for this important segment of the Society's Operating Fund budget. It is hoped that a careful watch and accounting over monthly budget results will enable the Publications and Finance Committees to maintain a balanced financial situation.

Membership Statistics

Changes in ISMS membership statistics for the past several years, as recorded in the Society's records, are indicated in the accompanying table.

	1968	1967	1966	1965	1964	1963
Membership as of January 1	10,568	10,607	10,626	10,500	10,145	10,101
New Members	425	515	517	492	537	429
Reinstatements	40	43	65	43	211	59
Total added	465	558	582	535	748	488
Dropped during the year:						
Died	205	211	191	172	175	176
Moved from State	50	151	172	101	47	60
Resigned	6	12	21	28	7	6
Nonpayment	145	223	217	108	164	202
Total dropped	406	597	601	409	393	444
Membership as of December 31	10,627	10,568	10,607	10,626	10,500	10,145
Regular	9,375	9,335	9,417	9,429	9,412	9,097
Residents	196	214	250	278	230	223
Service	105	59	51	26	30	13
Emeritus	507	514	484	494	459	467
Retired	403	399	349	334	312	328
Hardship	41	47	52	45	31	17
Intern			4	20	26	
Total	10,627	10,568	10,607	10,626	10,500	10,145

American Medical Association records indicate that at the end of 1967 (latest figures available), there were 14,652 "non-federal" physicians in Illinois, of which 674 were interns, 1,731 were residents, 904 were full-time hospital staff, and 842 were medical school faculty, administration or research. Thus, there were 10,501 physicians in private practice on a solo, partnership or group basis.

In no other profession does membership in a professional society matter so significantly to the general public and to the members as it does in medicine. With all levels of government so deeply involved in the distribution of medical services, no Illinois physician should feel that he can permit himself the luxury of not playing an active personal role in medical society affairs.

At the same time, membership benefits have been

increasing every year. A significant example is the addition in 1968 of a group insurance policy to cover malpractice liability.

Further defining the Society's services and benefits is a fine brochure recently completed by the Society's Public Relations Division and Membership Committee. A copy of this was sent to each delegate and county secretary early in 1969. This brochure was also mailed to interns and residents training in Illinois hospitals on the first of March, 1969. It is hoped that this and additional efforts by our local societies will obtain a larger number of hospital-based physicians as new ISMS members. Regardless of their claims and protestations, these physicians do benefit from the activities of organized medicine and there is no truly valid reason for their non-membership.

Financial Statements for 1968

Condensed financial statements are presented here for the benefit of the entire membership. The complete and detailed audit report prepared by Peat, Marwick & Mitchell & Company for the year ending December 31, 1968, will be distributed to each member of the House of Delegates prior to the meeting and is available for review at the headquarters office by any member upon request. A report containing the 1968 and 1969 budgets, along with the preliminary actual figures for 1968 (prior to audit), was provided by mail to each delegate during January, 1969. This is in keeping with the expressed request of the House that such information be provided no less than 60 days prior to the Annual Meeting of the House of Delegates. This will enable Delegates to review the Society's financial position, results of operations, and future planning well before the actual Reference Committee hearings.

At this time it might be well to briefly review the apportionment of the Society's income. Starting in 1966, the House of Delegates recommended that of the annual dues of \$105.00, \$70.00 be used for the Operating Fund, \$20.00 allocated for AMA-ERF, \$7.00 added to the Benevolence Fund, and \$8.00 set aside to build up the Permanent Reserve Fund. This formula has not changed except that in 1967, \$2.00 of each full-dues-paying member's dues was allocated to the Health Careers Council of Illinois from the AMA-ERF Fund and in 1968 the same amount was given HCCI from the Benevolence Fund. The build-up of the permanent reserves was made on the advice of the auditors and others experienced in organizational financing; that it should be the policy of an organization such as the ISMS to have a permanent reserve fund equal to one year's annual income. Incidentally, the IRS approves of such financing. At the end of 1968, the Society's per-

manent reserves amounted to approximately \$400,000 and, projecting future increases based on past experience, the desired goal will not be reached until 1973. Projecting farther, it might be possible to avoid a dues increase in 1972 or 1973 by then using all or part of this allocation for the Operating Fund to cover the "cost of living" or "doing business" increases, which by then will be a factor of major concern in the Society's budgeting if the increases of the past four years continue. This has averaged approximately 4% per year, using 1959 as a base of 100, with the index reaching 108.8 in 1965. (The figure for December 31, 1968, was 121.0 on this same basis.)

A copy of the projected budget for 1970 will be provided to each member of the House in advance of the 1969 Convention. It should be noted that the budgets developed for 1969 and 1970 are in balance, and do not include funds for any new projects. As stated in previous reports, *should the House of Delegates direct any new programs of a major nature, a recommendation as to the method of providing the necessary finances for them should also be provided by the House at the same time.*

In review, 1968 can be considered another successful one for the Illinois State Medical Society. Under the capable leadership of Mr. Roger White as Executive Administrator, the staff has functioned efficiently and effectively with unity of purpose, dedication to the principle of the Society's chartered aims and willing cooperation with the officers, Trustees and members. A debt of gratitude to them is acknowledged and appreciated. The combined efforts of the staff and the official leadership has made Illinois outstanding in medical prominence—a position of prestige which must be continued in the years to come.

Jacob E. Reisch

Illinois State Medical Society Position Statement—Dec. 31, 1968

ASSETS	Operating Fund	Benevolence Fund	Permanent Reserve Fund	Property Fund	Student Loan Fund	Suppl. Empl. Retirement Fund
Cash	\$314,381	54,136	77,529	10,664	3,325	24,141
Receivables	42,623				2,275	
Investments, at cost	100,000	148,860	173,933		42,500	
Student loans					69,083	
Prepayments and advances	7,067					
Office Furniture and Fixtures				88,293		
Interfund Receivables (Payables)	(208,397)	55,937	152,600	(140)		
Total Assets	<u>\$255,674</u>	<u>258,933</u>	<u>404,062</u>	<u>98,817</u>	<u>117,173</u>	<u>24,141</u>
LIABILITIES AND FUND BALANCES						
Payables	\$164,108					
Accrued expenses	3,000					
Deferred income	31,539	2,185	3,496			
Fund Balances	57,027	256,748	400,566	98,817	117,183	24,141
Total Liabilities and Fund Balances	<u>\$225,674</u>	<u>258,933</u>	<u>404,062</u>	<u>98,817</u>	<u>117,183</u>	<u>24,141</u>

Income Statement—Operating Fund—Year Ended Dec. 31, 1968

INCOME		EXPENSES	
Membership dues—		Board and Officers	\$ 46,382
Basic dues—\$105 per member	\$977,330	ISMS Meetings	32,372
Less Allocations		AMA Meetings	30,443
AMA-ERF—\$20 per member	186,115	Administration	64,667
HCCI—\$2 per member	18,611	Business Services—Admin.	183,473
Benevolence Fund—\$5 per member	46,529	Public Relations & Economics	99,905
Permanent Reserves—\$8 per member	74,446	Economics and Insurance	29,355
Total Allocations	325,701	Legislation & Public Affairs	84,824
Net Membership Dues	651,629	Springfield Office	45,516
<i>Illinois Medical Journal</i>	133,753	Education & Scientific Services	30,202
“Pulse” and “What Goes On”	44,100	Publications	13,512
Annual Convention exhibits	15,626	<i>Illinois Medical Journal</i> & Publ.	225,252
Interest and dividends	32,605		
All other	8,970	TOTAL EXPENSES	885,903
TOTAL INCOME	886,683	EXCESS OF INCOME OVER EXPENSES	\$ 780

Sub-Committee on Benevolence

The Benevolence Committee (at the time this report is being prepared) assists 29 individuals, 28 widows and one physician. Ten of the recipients are from Cook county and 19 from downstate.

During the past year, three recipients have been added, five have died, and one has been removed from the roll of recipients. At this time there is one case pending, and another on which additional information has been requested within the next 60 days, or assistance cannot be continued.

The investment of the committee surplus is handled in a custodial account at the Continental Illinois National Bank and Trust Company and investments are in common stock and commercial paper. (The financial statement of the committee forms part of the report of the treasurer and is available for the reference committee.) The charge for this custodial account is assumed by the committee and charged to the general funds of the Society. Under the Bylaws, funds in the Benevolence Account are payable only to recipients. In the general Financial Statement you will find the committee expenses listed at \$800 and this total includes the cost of the custodial account, as well as the general committee expenses.

Several years ago the committee established some gen-

eral rules and regulations under which it operates. They are called to your attention again to give you the guidelines set up for the assistance of former members, their widows or widowers, and dependent children:

1. No committee funds are expended for funeral expenses.
2. All recipients must have applications filled out by the individual himself, or by his representative.
3. All recipients must personally desire the assistance offered.
4. The circumstances of each recipient must be reviewed by a member of the Society, a member of the Auxiliary, a county medical society officer, etc., so that an adequate appraisal can be made. This personal investigation is desirable whenever possible before any committee action is taken.
5. The power of attorney (or a copy) should be on file in all cases where this is indicated.
6. All cases are to be reviewed annually with personal investigations whenever possible. A questionnaire is to be used to keep information current and accurate.

Keith H. Frankhauser, *Chairman*
Leo P. A. Sweeney Allison L. Burdick, Sr.



MEDICAL LEGAL

Medical-Legal Council

During the course of the past year the Medical-Legal Council has concerned itself chiefly with the problem of malpractice claims. Discussions have been held jointly with the Chicago and Illinois Bar Association to consider the possibility of setting up a Malpractice Screening Panel. The proposal would work as follows: A panel would be set up consisting of two lawyers, two physicians, and a judge. Either before or following the filing of suit the parties could agree to present their case to the panel. If the panel concludes that there is merit in the claim, it recommends a settlement. If the panel finds that there is no merit, it recommends that the suit be dismissed.

Under the plan, expert testimony must be provided in cases involving meritorious claims. Where the claim lacks substance the plaintiff's lawyer must withdraw, as previously agreed, prior to submitting the case to the panel.

Noel G. Shaw, *Chairman*
Clinton L. Compere
William G. McCarthy

The Medical-Legal Council has reviewed the New Jersey Malpractice Plan which has been in operation for several years. Statistics from that state indicate that in almost all the cases brought before the panel, a determination in favor of the plaintiff has been made. This would seem to indicate that under a voluntary system the "nuisance" cases are not being presented to the panel. Your Council hopes to work out a plan whereby all malpractice claims will be reviewed by the Screening Panel. A specific proposal to this effect has been made to the Bar Association.

The plan, whatever its final form, could be implemented by a change in the Supreme Court Rules, rather than through legislation. This is an area which is of utmost concern to all physicians. Your Council will continue to pursue a feasible solution to the problem of malpractice liability.

George Alvary,
Andrew John Toman
Grover L. Seitzinger

ETHICAL RELATIONS COMMITTEE

The major function of this committee is to review, upon appeal, disciplinary actions taken at the County or District level. No cases were referred to the committee as of the time this report was prepared.

The committee has met once to consider a complaint against Ethical Relations Committee procedures at the County Society level. The complaint reads as follows:

"The Officers and Trustees of the Chicago Medical Society are greatly alarmed over the fact that the By-Laws of the Illinois State Medical Society in Chapter XII, Part I, state that a member being investigated by the Ethical Relations Committee may have legal counsel, who in turn may cross examine witnesses. This makes it practically mandatory that the trial body also have counsel. Thus the trial becomes an expensive legal procedure rather than a trial by the respondent's peers."

Your committee agrees that the use of legal counsel at these hearings should not be made mandatory. Accord-

ingly, the present wording uses the phrase *may* be represented, rather than *shall* be represented. Upon the advice of legal counsel, however, your committee believes that the accused should not be denied the use of legal counsel if he so requests. To do so would jeopardize the actions taken in the event the member is expelled and later seeks recourse through legal channels.

To resolve the problem your committee makes the following **recommendation**:

That Chapter XII of the Constitution and By-Laws be amended by removing all references to legal counsel and substituting the word "counsel" as appropriate.

In adopting this recommendation the accused may utilize counsel supplied by a medical colleague or by legal counsel as he chooses.

Willard C. Scrivner, *Chairman*
J. Ernest Breed
William A. McNichols, Jr.
Newton DuPuy

IMPARTIAL MEDICAL TESTIMONY

During 1968, specialists from the Impartial Medical Testimony panel participated in 63 impartial medical examinations. Forty-three (43) of these appointments were for the Illinois Circuit Court, and 20 were for the United States District Court of Northern Illinois.

As in the past, most of the IMT orders came from Cook County, and the majority were requests for orthopedic examinations and reports.

The change in the Supreme Court Rule in January, 1967, which permits the use of IMT panelists in other than personal injury cases, has not resulted in a major increase in use of the Rule. The recent change in the administrative procedure, whereby the ISMS rather than the court office arranges for the time and place of the examination, has worked well for the last year. This has eliminated the possibility of misunderstanding between the court and the physician, who may be unavailable when the court's request is issued.

The IMT Committee is currently adding to the panel specialists in the fields of orthopedic surgery, neurology, and neurosurgery from the Chicago area. Efforts will be continued to anticipate the needs from the downstate areas. The use of the procedure is infrequent in these regions and for the present it is more feasible to operate on an ad hoc basis.

The IMT program continues to provide valuable service to the Illinois and U.S. District Courts. Since its original implementation, it has been a vital factor in the resolution of over 225 cases. Most of these litigations were of an unusually tough and serious nature.

Your Committee will continue to maintain active liaison among physicians, the bar, and the judiciary.

Those physicians who serve on the panel have earned the thanks and respect of every member of the Illinois State Medical Society.

Clinton L. Compere, *Chairman* Maurice D. Murfin
R. Gregory Green Samuel A. Levinson, *Consultant*
Jerome J. McCullough Vincent C. Sarley, *Consultant*

COMMITTEE ON LABORATORY EVALUATION

The Committee on Laboratory Evaluations has met several times during the past year to review and recommend legislative additions and changes in the Clinical Laboratory Act, the Blood Bank Act and such other acts which effect the practice of medicine in clinical laboratories.

Clinical Laboratory Act: The Committee has studied Section 7-105 of the Clinical Laboratory Act and has recommended that this Section be amended to adopt advertising prohibitions identical to those of the Medical Practice Act. It also recommended that a Director of a clinical laboratory be required to hold a doctoral degree

rather than a master's degree, as is presently required by the Act.

A number of technical changes in the Clinical Laboratory Act and the Illinois Blood Bank Act have been worked out with the Department of Public Health. These changes are non-controversial and are directed by several years of experience in operating under the Act.

Sale of Blood and Human Tissue: The Committee on Laboratory Evaluation has recommended that the sale of blood and human tissue be defined by statute as the sale of a service and not a product. An Act defining it as such has been drafted by Legal Counsel and has been reviewed by the Committee. This Act was to be presented to the 76th General Assembly.

Illinois Blood Bank Act: The Committee has studied a proposed amendment to the Blood Bank Act, Section 7-104(a) which would define plasmapheresis and require that a physician be present when it is to be performed.

All of the above recommendations of the Committee have received the approval of the Council on Legislation and the Board of Trustees. Hopefully, they will become part of Illinois' Revised Statutes by the end of the 1969 legislative session. The Chairman and other members of the Committee on Laboratory Evaluation will be available to support this legislation in whatever way possible.

Grover L. Seitzinger, *Chairman*

Ronald Jessen

Hans D. Willuhn

Jack Williams

James Hartney, *Consultant*

COMMITTEE ON MEDICAL PRACTICE AND QUACKERY

The Committee on Medical Practice and Quackery reviewed and discussed the program presented at the AMA Quackery Conference and Seminar on Chiropractic Legislation.

There was a request from the Department of Registration and Education that the Illinois State Medical Society provide expert medical testimony in cases of malpractice and quackery, which might come up before the Department. The Committee unanimously approved the request. A list of physicians in the State who would be willing to testify in such matters should be compiled.

It was recommended to the Board of Trustees that the Committee on Medical Practice and Quackery be allowed to set up a routine mechanism to provide medical expert testimony in such cases.

It was recommended that the medical schools in the State of Illinois provide in their curriculum some class time allotted to lectures on quackery and specifically problems of quackery in the field of chiropractic in the State of Illinois.

William G. McCarthy, *Chairman*

Ross Hutchison

Elliot Parker

Raymond B. Murphy

Wilson West

E. A. Piszczek, *Consultant*

ATTEND FORMAL OPENING OF EXHIBITS

Monday, May 19—Mezzanine

11:00 a.m.



LEGISLATION & PUBLIC AFFAIRS

COUNCIL ON LEGISLATION AND PUBLIC AFFAIRS

The Council on Legislation and Public Affairs has met several times since the last meeting of the House of Delegates. At least one additional meeting will be held prior to the Annual Meeting. Following each meeting, the council has reported in detail to the Board of Trustees and to the membership through the special legislative newsletter "On the Legislative Scene."

Federal Legislation

The 90th Congress, which convened in January, 1967, ended its second session October 14, 1968—just three weeks before the 1968 national elections. Of the 29,132 bills introduced in both sessions, 1,435 related to health care. Only 31 health measures were actually enacted into public law. For the most part 1968 was a *go slow* year for new legislation. Practically all of the bills which passed were consolidations or extensions of existing programs. Among the significant health measures were the establishment of an Eye Institute under the National Institutes of Health, increased support for medical manpower and the classification of LSD under the Dangerous Drug Act.

There were many reasons for the reduced pace of federal legislation in 1968 including the election of a more conservative congress in 1966. Perhaps the most cogent reason for caution was a real need to evaluate the many programs passed earlier, which have resulted in extensive duplication and waste.

Despite some cutbacks it is interesting to note that the appropriations made in the 2nd session of the 90th Congress, to carry on the federal government's health activities, was \$16.8 billion for fiscal 1969 (July 1, 1968 to June 30, 1969). This is an increase of \$1.26 billion over the previous fiscal year. The individual beneficiaries of these programs now total 8,132,637.

The 91st Congress convened January 3, 1969, and 2,379

bills were introduced the opening day. Medically related bills will again have a prominent position in the Congress. However, the new Republican administration has indicated that it will not submit major new administrative programs nor call for drastic amendment of prior law during the first session.

Legislative matters of primary concern to medicine during 1969 will include proposals to amend the Medicare Law in such areas as inclusion of other Independent Practitioners under Part B, increasing benefits for the mentally ill, preventive care as a Medicare benefit, removal of the deductible and co-insurance features of Title 18 and a redefinition of hospital services under Part A to include certain professional services. Of primary concern to some legislators and HEW authorities is the establishment of a method for limiting costs through establishing a schedule of fees for physician's services. In fact, directives have recently been issued to Part B carriers by HEW, which in effect place strict limitations in this field.

Other matters that will assume the spotlight in 1969 include a continuation of the Nelson drug hearings, continuation of hearings on health care costs, amendments to Hill-Burton programs, and air and water pollution control.

Also, lengthy hearings were begun early this year by the House Committee on Ways and Means to consider major revision of tax laws including probes into the tax exempt status of organizations and the matter of whether advertising income to scientific magazines should be characterized as unrelated business income. This issue is of great importance to the American Medical Association and some state medical societies.

Testimony will be presented to a number of Congressional Committees by the AMA during 1969 providing leadership and recommendations related to many of the issues before Congress.

The Illinois State Medical Society will continue its close cooperation with the American Medical Association in an effort to improve medicine's effectiveness in legislative and public affairs programs.

State Legislation

During the 1968 House of Delegates, your Council reported the status or results of proposed legislation affecting medicine, physicians and the health of the citizens of Illinois. Although a special session was called several times since the Annual Meeting, the 76th General Assembly convened Jan. 8, 1969. The 76th General Assembly continues to meet and a deadline date of April 11 has been set for the introduction of bills (other than "consent bills" which have the support of both parties' leadership and are not opposed).

The Uniform Anatomical Gift Act, endorsed by the AMA at its December, 1968, convention and the ISMS Board in its January session, was introduced in both the House and Senate. The Act passed in the House and is scheduled for hearing in the Senate. ISMS is supporting this bill which would provide a model relating to the gift and use of organs and tissue for transplant. This is a major step toward resolving the many legal uncertainties in existence, and at the same time remain cognizant of the need for unhindered medical judgment.

The controversial Artificial Insemination Bill (H.B.9) received a "Do Pass" recommendation from the House Public Welfare Committee. The central issue—and deciding factor on the vote was the "legitimizing" of any offspring resulting from this procedure. The bill requires involvement by the Ill. Dept. of Public Health—an estimated \$85,000 would be necessary for administrative and clerical work connected with such a program. Many questions on morality, religion and implementation have been raised with regard to artificial insemination: adultery, incest, financial compensation, divorce and support, and physical requirements, to name a few. Rep. Daniel Pierce, sponsor of the bill, was asked to clarify the term "physician" through an amendment to read "physician licensed to practice medicine in all of its branches."

The 1967 and 1968 House of Delegates action resulted in a bill drafted and introduced into the 76th General Assembly declaring that injection, transfusion or transplanting of blood, corneas, bones, organs or other human tissue constitutes the furnishing of a service rather than sale of any such item. This bill was assigned to the House Judiciary Committee for hearing and is expected to pass. The same legislation has been approved in 15 other states.

S.B. 84, introduced by Sen. Jack Knuepfer, was introduced as a direct result of a resolution he introduced in the Senate last summer. The bill amends the aggravated assault and aggravated battery section of the Criminal Code to include a paragraph covering medical and allied personnel during a riot or civil disturbance.

An amendment to the Uniform Narcotic Drug Act reduced the penalty for first offenders convicted of possessing or having control of 5 grams or less of marijuana.

A bill introduced on March 4, S.B.425, would create a driver's license Medical Advisory Board. ISMS concurs with the suggestions made by the Committee on Public Safety of ISMS. The bill contains a requirement that "all physicians in all State or public and privately operated clinics and hospitals be required to report to the Department of Public Health the name, address, social security number, and condition of any person above fifteen years of age, who has been examined or

treated and has any of several listed physical or mental deficiencies or disabilities. Briefly, this is mandatory reporting to which we are unalterably opposed. Your Legal Counsel was directed to draft an amendment redefining "physician" to read "physician qualified to practice medicine in all of its branches," and delete the mandatory provisions for reporting.

The Council considered S.B.90, introduced by Senator Lanigan. The intent of this bill is to amend the Medical Practice Act to exempt persons licensed under said act from civil liability as a result of their voluntarily rendering aid in emergencies. This is an extension of the "Good Samaritan" legislation. This particular bill is only one of three that were introduced. (The other two pertain to dentists and nurses.) At the present time, the statute includes emergency care only at the scene of a motor vehicle accident or in the case of nuclear attack. The proposed legislation attempts to include all emergency care.

Several bills were introduced concerning abortion by Rep. Leland Rayson. The bills were referred to the Public Welfare Committee for hearing. However, another state representative, Bernard Wolfe, has indicated that he will introduce additional abortion bills for consideration. The Council plans to thoroughly study proposed legislation in this area before recommending action to the Board of Trustees.

V. P. Siegel, *Chairman*

Richard Allyn
Alfred J. Faber
Theodore Grevas

Frank J. Kresca
Eugene J. Scherba
Thomas P. deGraffenried

Consultants

H. Close Hesselstine
Harold A. Sofield

J. Ernest Breed
William A. Lees

Mrs. Alan Taylor, *Auxiliary Representative*

PUBLIC AFFAIRS COMMITTEE

The ISMS Public Affairs Committee has met three times since the 1968 Annual Meeting. "Educate for '68" was the theme of the 1968-69 program with special emphasis given to the role of the physician and his wife in the 1968 elections. To aid the physician in political education and activity, a comprehensive program was developed and implemented:

Meetings: Each county medical society was encouraged to sponsor a public affairs program during the year. A list of audio-visual materials and booklets is available for program planning. Lake, DuPage, and Champaign counties invited local doctors to hear speakers such as Political Editors Charles Nicodemus and Norton Kay. Some 450 physicians attended these county meetings. Many of the larger counties were hosts to Regional Public Affairs meetings throughout the state. Held in cooperation with ISMS, the meetings brought together physicians from neighboring counties to hear speakers Sen. Howard Baker, Jr., Rep. Gerald Ford, Columnist and Author Robert Novak, and other nationally known speakers.

As part of the 1968 President's Tour, a public affairs speaker was secured to address groups of physicians. Following a one-day Government Workshop, groups of doctors heard from ISMS President Philip G. Thomsen and a local Congressman or state legislative leader. These meetings were held in each ISMS district.

On Oct. 6, the annual ISMS Leadership Conference was held in Springfield. The entire afternoon session was devoted to topics of political interest. Congressmen

George Shipley, Donald Rumsfeld and Paul Findley participated in a Congressional panel; Columnist Robert Novak spoke on "Political Perspectives" and Dr. Philip Thomsen spoke on the 1968 elections. The dinner speaker was U.S. Senate Minority Leader Everett M. Dirksen.

Monthly Newsletters: During 1968, over 2,700 physicians received monthly newsletters on various political topics. "Educate for '68" was a political education bulletin containing information on voting procedures, party nominations, the electoral college, and absentee voting. "On the Political Scene" brought the physician "behind the scenes" of current political developments and personalities. During the Illinois legislative session, this newsletter is replaced by "On the Legislative Scene" which reports House and Senate floor action, committee recommendations, and newly introduced bills submitted for consideration, as such may affect physicians and the practice of medicine. County public affairs chairmen received a special communication "Public Affairs Chairmen's Bulletin" monthly which suggested local public affairs projects and brought the chairman up-to-date on pending ISMS programs. Beginning in June, 1968, Auxiliary public affairs and legislative chairmen received a similar bulletin.

Washington Roundup: The Annual Washington Public Affairs ROUNDUP was held Feb. 16-18, 1969, in Washington, D.C. The afternoon program featured speakers William Rusher, Publisher of *National Review* magazine; Walter Trohan, Washington Bureau Chief of the *Chicago Tribune*; and James Foristel, Legislative Representative of the AMA. Highlighting the ISMS program was a reception with Illinois Congressmen and Senators and their wives. The ROUNDUP program is held in conjunction with the Association Public Affairs Conference of the U.S. Chamber of Commerce. Over 75 Illinois physicians and their wives travelled to Washington to participate in this program.

Election Projects: Two programs were especially devised for the 1968 elections. "Meet the Candidates Nights" were held in the Aux Plaines, Douglas Park, Irving Park, and North Shore branches of Chicago Medical Society. The evening provided an opportunity for local physicians to meet with candidates for local, state and national office seeking election. Both political parties' candidates were invited. The North Shore Branch meeting had an attendance of 400 to hear Sen. Dirksen and Congressmen Rumsfeld along with other candidates.

A supplemental fact sheet on the Call for a Constitutional Convention (Con-Con) and the Resources Development Bond Issue (Pollution Abatement program) was included with the monthly public affairs newsletters. Articles on these two issues confronting the voter also appeared in the *Illinois Medical Journal* and *Pulse*.

Public Affairs Library: A new public affairs program, the Public Affairs Library began in December, 1968. Reviews on newly released and recent books appear in the *Illinois Medical Journal* monthly. Subject matter reviewed includes politics, legislation, political parties, voting trends, the Supreme Court, media and government, and parapolitical topics. Local public affairs chairmen receive a book review sheet directly and are asked to report on one book at each monthly medical society meeting. Interested physicians can borrow or purchase the books from the ISMS Library.

Auxiliary Programs: The ISMS Auxiliary had an active year in public affairs activities. PROJECT 24, a program encouraging each Auxilian to devote 24 hours of volunteer work to the candidate of her choice was

very successful. Each participant was asked to keep a time card listing the political activity, and how many hours were worked. The completed time card, signed by the candidate, was then submitted to ISMS. In recognition for her dedication, she received a Public Affairs Award and a Congressional keychain presented at the local Auxiliary meeting. Some women devoted as much as 200 hours!

An Advanced Political Education Seminar was held in Springfield on Oct. 6. Mrs. Pam Taylor, Auxiliary Legislative Chairman, presided over the meeting which featured speakers Richard Lockhart, James Brady, Roger White and James Imboden. Other public affairs meetings were held in various counties throughout the state.

Annual Public Affairs Dinner: A Public Affairs Dinner is held annually during the ISMS Annual Meeting in May. Last year approximately 400 physicians heard U.S. Senator George Murphy speak on national issues. Arrangements are being made for another nationally prominent speaker for the 1969 May Dinner.

During the AMA Convention in San Francisco, the ISMS Public Affairs Committee received a special feather in its cap. Theodore Grevas, Chairman of the Committee, presented a resolution for the AMA to adopt a public affairs program on the national level. This resolution came as a direct result of action taken by the ISMS House of Delegates at their Annual Meeting in May, 1968. The resolution was adopted by the AMA and a new Division of Public Affairs has been formed. Heading the new Division is Joe Miller, former Executive Director of the American Medical Political Action Committee (AMPAC). The AMA program will involve thousands of physicians throughout the country in public affairs activities.

Theodore Grevas, *Chairman*

EYE COMMITTEE

The Eye Health Committee has held two joint meetings with the Illinois State Joint Council of Ophthalmology. One took place in May, 1968, and the second on Dec. 16, 1968. The organization's primary functions are to keep abreast of ophthalmological problems and to concern themselves with legislation and public relations related to eye care on the state level. Another important function is to maintain regular liaison with the Illinois State Medical Society. During the May joint meeting three important items on the agenda were discussed.

1. Formation of a "contact lens" policy on the state level.
2. Consideration and investigation of the present non-conventional expensive (in our opinion) ineffective method of treating dyslexia, muscle imbalance and refractive errors based on a controversial method using the Dolman-Delacoto technique primarily used by non-medical practitioners.
3. Coding System for diagnosis and procedure concerning medicare and public aid recipients.

It has become apparent on the state level that something must be done about standardizing the manufacturing, fitting and follow-up care of contact lens wearers. There seems to be no disagreement that ophthalmologists should take this responsibility.

The Committee realizes that we have to do some basic research and then take the lead in educating the public and public officials. The problem of dyslexia is being researched in scientific ophthalmological papers and slowly creeping into the literature. The ophthalmic profession

is waiting for more scientifically worked out information concerning the problems before it makes a stand against this type of treatment. Your Eye Committee has arranged to present a panel of experts on dyslexia at the Illinois State Medical Society Annual Convention in May, 1969.

The coding system for diagnosis and procedures with medicare recipients was discussed with representatives of

the Continental Casualty Company, Blue Cross-Blue Shield, and the Illinois Health Council. It is apparent that the rules and regulations in the Social Security system would have to be changed nationally before something could be worked out. We are in contact with the American Association of Ophthalmology and other societies regarding this matter.

Frank J. Kresca, <i>Chairman</i>	
Edward C. Albers	Lawrence J. Lawson
Wilbur W. Baumgartner	Charles L. Pannabecker
David V. Brown	David Shock
James R. Fitzgerald	Manuel Stillerman
Max Hirschfelder	M. Byron Weisbaum
Maurice M. Hoeltgen, <i>Consultant</i>	

PLAN TO ATTEND THE

Sixth Annual

PUBLIC AFFAIRS DINNER

at the

Illinois State Medical Society

Annual Meeting in May

Monday, May 19

Bal Tabarin

Sherman House

6:00 p.m. Reception

7:00 p.m. Dinner

\$10 per person

Principal Speaker:
U.S. Senator Robert W. Packwood (R.-Oregon)

MEDICAL SERVICE



Council on Medical Service

The Council on Medical Service met twice during the past year. Its principal areas of concern were: (A) Promotion of the new ISMS Malpractice Insurance program; (B) Promotion of the Society's TV Series, "The Time of Your Life;" and (C) Establishing a new Advisory Committee to Division of Vocational Rehabilitation. This committee—whose duties will be similar to the Advisory Committee to IDPA—was established last February with Dr. Eli Borkon as chairman. We expect to launch the committee's programs this summer. These and other Council projects are discussed in the following committee reports.

Fred Z. White, *Chairman*

Preston S. Houk

T. T. Tourlentes

Fred A. Tworoger

COMMITTEE ON AGING

The Committee on Aging's 13-part half-hour television series, "The Time of Your Life," has enjoyed significant success in Chicago and Moline TV showings. The programs featured popular broadcast personality Norman Ross, who interviewed recognized authorities on important pre-retirement planning aspects, such as financial and estate planning, medical expenses, physical and emotional problems, and the constructive use of leisure time.

The series—co-sponsored through a grant from Blue Shield Plan of Illinois Medical Service—was initially presented in "prime" time by WTTW-TV, Channel 11, Chicago, last summer. ISMS received more than 3,000 requests for the accompanying booklet offered on the program. Following that, the series was telecast on WQAD-TV, Moline. The series also is expected to be shown on at least two other downstate stations this year.

A promotional brochure on the series has been planned for distribution to industry, clubs and schools this Spring. The brochure will offer the films and tapes of the program for rental, leasing, or purchase.

Workshop on Health Care

As part of its continuing efforts toward improving care for the aged, the Committee is planning to conduct a "traveling seminar on care of the aged" during the 1969 Annual ISMS Meeting. Seminar participants will be transported by tour bus to each of the three general types of facilities specializing in long term care of the elderly (proprietary and non-proprietary nursing homes and sheltered care facilities) where discussions on each type of placement and management will be held.

Letters to Medical Schools

The Committee has communicated with the five Illinois Medical School Deans recommending that a formal training program be offered to medical students in the multi-disciplinary approach to economics, administration and para-medical problems of health care of the aged. Encouraging replies have been received. Some work already is being done, and all are aware of the need.

The Chairman commends all Committee members who have participated with enthusiasm and creativity throughout the year.

This report is for information only, and requires no action by the reference committee.

Thomas T. Tourlentes, *Chairman*

Marshall Falk

Bertram B. Moss

M. H. Powell

Ralph A. Rittenhouse

Clyde Rulison

Mrs. Herbert P. Swartz

Auxiliary Representative

COMMITTEE ON MEDICAL ECONOMICS AND INSURANCE

During this past year, this Committee devoted its major effort to the evaluation and implementation of the ISMS-sponsored programs listed below. An additional effort was an educational program for our membership, to aid their understanding and utilization of these programs. Informational mailings as well as news items and columns for the *Illinois Medical Journal*, *Pulse*, etc. were discussed. Arrangements also were made for speakers for several County Societies.

Under the aegis of this committee are the following:

Professional Liability Program

The ISMS-sponsored Professional Liability (Malpractice) Program, approved by the Board of Trustees in January, 1968, began enrollment in June, 1968. The rapid growth in numbers of enrollees—approaching 550 at the time of this report—must attest to the need for, and acceptance of, this program. The carrier, in accord with our agreement, has accepted members into this program regardless of age or specialty. In the very few instances in which acceptance was questioned, referral was made to this committee. A workable method of review was devised, and, although this may eventually require refinement, it is adequate at this time. In all cases final disposition of the questioned cases was made to the satisfaction of the committee.

The committee feels that although additional developmental efforts must be made, this program is well launched, has met the immediate needs of our members, and will offer the long-term reward of an improved legal climate for our membership.

Major Medical Expense Plan

This plan, underwritten by the Commercial Insurance Company of New Jersey and approved by the Board of Trustees in 1965, has experienced rapid, sustained growth. A rate increase, effective Aug. 1, 1968, had no appreciable effect on renewals, the non-renewal rate being very close to the usual 3½%.

The committee approved an optional extension of coverage that would increase daily room and board rates from \$30 to \$50, and the maximum medical expense indemnity from \$15,000 to \$25,000. Rates for standard coverage will not be changed. Full announcement of this optional additional coverage was to be made.

Group Disability Program

The oldest of the ISMS-sponsored insurance programs, the Group Disability Insurance Plan—underwritten by the Commercial Insurance Company of New Jersey—was first offered in 1946 and was formally endorsed by the Board of Trustees in 1963. Enrollment includes over one-third of the Society's eligible members. Because of a favorable balance in the participating age groups, the program has been successful and actuarially sound. And because it is a sound program, our administrators, Parker, Aleshire & Co., were able to secure an extension of coverage—effective April, 1969—providing additional protection for subscribers, including those who transfer membership to another state. This additional coverage has been effected without increase in cost.

Retirement Investment Program

This program, endorsed by the Board of Trustees in 1965, is designed to protect physicians against periods of inflation and recession by investing their contributions in a combination of a Continental Assurance Company Group Annuity and a no-load Stein Roe & Farnham (Mutual) Stock Fund. With this plan the physician does not have to include his employees in the program, as he must under the Tax Qualified Program.

Because of the greater physician interest in the Tax Qualified Program, this retirement investment program was not greatly emphasized this year. Participation remains good, however.

Tax Qualified Retirement Program

Liberalization of the Keogh Act (HR-10) to permit

tax deductions to the full amount invested increased membership interest in the ISMS-sponsored Tax Qualified Retirement Program this year.

The number of participants has more than doubled; from 156 at the end of 1967 to 370 at the end of 1968. The total amount invested rose from \$497,374 to over \$1 million in the same time. Of this total, the Stein Roe & Farnham Fund holds \$930,000; while there is \$132,000 invested in the annuity plan. The proportion invested in the annuity and stock funds as expressed by these figures is in accord with trends in similar plans throughout the country.

Extensive discussion with Mr. Robinson, administrator of these two plans, has served to clarify points in regard to their administration, and has resulted in the acceptance of specific Guidelines delineating responsibility and methods to be followed. These Guidelines should make the plans more understandable to our members and provide more precisely reportage to each participant on his present standing and ultimate expectation under the plans.

The Keogh Plan represents a sizable financial holding for members of this Society, and thus should be closely observed by this committee with the help of information gathered by the specialists on ISMS staff.

Catastrophe Liability Insurance

As authorized by the Board of Trustees, the committee again investigated the possibility of an ISMS plan offering its members a \$1 million Professional Personal Catastrophe Liability Insurance Policy. Efforts are now underway to obtain such coverage from the carrier for the basic ISMS Professional Liability Plan. If this can be accomplished, many benefits will be made available to our membership that could be achieved in no other way. For this reason the committee decided to await development without carrying on additional exploration.

Group Workmen's Compensation

The committee received a suggestion from a Missouri insurance company that it sponsor a Group Workmen's Compensation program, but tabled the idea after receiving this opinion from ISMS Legal Counsel Frank M. Pfeifer:

"Illinois physicians not being engaged in an extra hazardous business do not come within the provisions of Workmen's Compensation unless they specifically elect to do so. I do not believe that many physicians carry this type of insurance and see no real reason to do so."

ISMS Membership Survey

The committee discussed the medical-cost questions in the ISMS Survey of last August that had been referred to it by the Board of Trustees.

The questions and the committee's determinations were as follows:

- 1-a A voluntary pledge by ISMS members to set a one-year moratorium on fee increases? The committee agreed with the membership majority which rejected this proposal. However, the committee urges restraint in raising fees except when the cost structure dictates otherwise or the physician's fees have been relatively low.
- 1-b Concerted efforts by the medical profession to broaden the ambulatory benefits of private health insurance? The committee concurs with the membership in favoring this proposal, and believes it should be implemented through concerted cooperation with hospitals and insurance companies.

1-c Growth of medically controlled group practices (multispecialty)? The committee believes one approach to restraining costs is development of efficient, voluntary, medically-controlled practices of a group nature. It also feels that the physician whose inclinations are toward solo practice should be encouraged to develop techniques of sharing certain expenses, facilities, etc.

1-d Arrangements whereby the physician would conduct his practice in a hospital complex without losing his self-employed status? The committee does not believe this proposal would result in an appreciable cost reduction. Any saving in his sharing of equipment, it feels, frequently would be offset by high hospital rates for laboratory, X-ray and other procedures.

Features in *Illinois Medical Journal*

The committee is sponsoring in the *Illinois Medical Journal*—effective with the March, 1969 issue—a monthly series of questions and answers on the five ISMS-sponsored insurance programs. This series is to appear in the *Journal's* expanded, insert-type socio-economic section. The committee also encouraged—though it does not sponsor—the new series on Practice Management in that section. In addition, the committee chairman has been giving interviews on insurance matters in *IMJ*.

Frederick Z. White, *Chairman*

Don Mitchell

H. P. Swartz

A. Everett Joslyn, Jr.

Lawrence J. Knox

James B. Flanagan

John M. Coleman

Paul Van Pervis

COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATIONS

The Committee on Prepayment Plans and Organizations worked assiduously during the year to develop smooth mechanisms for appeals on third-party payments. Most important, it sought to develop guidelines that finally would win Board of Trustees approval.

Guidelines

At the request of the Board, the committee revised its guidelines for review procedures to avert any conflicts with those of Chicago Medical Society. Toward this end it conferred with Maurice M. Hoeltgen, M.D., chairman of the CMS Committee on Prepayment Plans and Organizations.

The revised guidelines are more permissive than the previous version . . . substitute the descriptive title "Guidelines" for "Rules and Procedures" . . . spell out "suggested" rather than "required" steps in county and district reviews . . . and eliminate several of the deadlines earlier prescribed.

Insurance Company Complaints

The committee invited insurance companies to use the ISMS Division of Public Relations and Economics as a clearing house for downstate complaints on physicians' charges. The division would channel the complaint to the prepayment plans committee of the appropriate county medical society; if no such committee exists, it would be sent to the ISMS Prepayment Plans Committee for referral to a district committee.

The Committee returned a decision on one fee dispute during the year. No appeals are pending.

This report is for information only and no action is required by the reference committee.

Preston S. Houk, *Chairman*

C. P. Cunningham

B. A. Kinsman

Philip Lynch

Theodore J. Wachowski

James P. FitzGibbons

Jacob E. Reisch

Consultant

ADVISORY COMMITTEE TO ILLINOIS DEPARTMENT OF PUBLIC AID

The Advisory Committee to the Illinois Department of Public Aid, convening prior to each Board of Trustees meeting, covered a wide range of problems during the year, reflecting the many facets of medical participation in Medicaid. The committee strove for definitions of procedures as well as for development of broad policies.

Group Practice Billings

One of our important objectives is a clear policy on billings by physicians engaged in group practice. Employing physicians—as ostensible supervisor of the employed MD's—have been signing the billing forms submitted to IDPA. Complications have arisen, however, because IDPA—under recent amendments to the Social Security Act—now requires a written billing agreement from every individual providing medical care for public-aid recipients. Also, there is a question about what constitutes "direct" billing.

To resolve the issue, the chairman appointed a sub-committee to meet with Henry A. Holle, M.D., IDPA medical director, and report back to the committee.

The committee—cooperating with the Committee on Usual and Customary Fees—played a role in reviewing and modifying the new IDPA-required agreement with physicians.

Non-Physician Practitioners

The committee was vigilant in recommending controls on public-aid participation by non-physician practitioners. It approved a proposed policy on the nature of podiatrist services to be recognized and reimbursed by IDPA. It advised IDPA not to recognize chiropractic as "essential care" for public-aid recipients. The Illinois Chiropractic Society had asked IDPA for such recognition, pointing out that its practitioners are licensed under the Illinois Medical Practice Act.

Other Activities

Also during the year, the committee reviewed a number of cases involving billing or other irregularities by physicians and made recommendations to the IDPA.

The committee appreciates the cooperation of Mr. Harold O. Swank, Dr. Holle, Mr. Robert G. Wessel of IDPA, and is particularly grateful to the ISMS staff for its valuable help.

This report is for information only, and no action is required by the reference committee.

Fred A. Tworoger, *Chairman*

Rex O. McMorris, *Vice-Chairman*

Louis Arp, Jr.

Charles E. Baldree, Jr.

James R. Cooper

Herbert Fine

George F. Lull

George T. Mitchell

Robert C. Muehrcke

Frank B. Norbury

Alphonse L. Robinson

William Scanlon

John H. Steinkamp

R. Kent Swedlund

Jacob E. Reisch, *Consultant*

Sub-Committee on Drugs and Therapeutics

During the past year, the Sub-Committee on Drugs and Therapeutics met several times to refine the drug list contained in the Illinois Department of Public Aid Drug Manual.

In order that the manual will reflect the prescribing habits of Illinois physicians, the committee spent many hours reviewing physicians' requests for drugs not listed in the manual. A complete and accurate record of requests and committee actions are kept in the society's office.

In 1968 the committee reviewed 1,124 written requests for drug usage. Approximately 99 per cent were approved.

The committee also reviewed numerous requests from pharmaceutical companies and has taken action at their request. Numerous drugs have been added and those that have not been utilized—or have been taken off the drug market by the Food and Drug Administration—were removed. The committee strives to maintain current and accurate information in the Drug Manual.

The question, "Do you favor prescribing drugs by their generic name whenever feasible"—which was directed to ISMS members in a recent socio-economic survey—was referred to this committee for study and recommendation. "The basic philosophy put down by the ISMS Board of Trustees and directed to the Drugs and Therapeutics was that, whenever feasible, the generic names be used. This has been followed by the Drugs and Therapeutics Sub-Committee since its formation."

In recognizing the time and efforts expended by the two consultants to the Sub-Committee on Drugs and Therapeutics, awards of appreciation were presented to Theodore Sherrod, M.D., and Louis Gdalan, R.Ph., by the ISMS Board of Trustees. A statistical study was initiated based on physicians billing IDPA for services rendered subsequent to January 1, 1967, by year of graduation from medical school, based on bills paid through June, 1968. Vitamin preparations and information pertinent to their usage will be the next area for a statistical study.

The committee appreciates the cooperation it has received from the physicians as a whole. It welcomes their comments and will be guided by their sound therapeutic suggestions when making recommendations to the IDPA for future revisions of the Drug Manual.

This is a report of information and no action is required by the reference committee.

Robert C. Muehrcke, *Chairman*

Joseph D. Cece

Richard L. Landau

Charles R. Frazer, Jr.

Kenneth Kessel

Louis Gdalan, R.Ph., *Consultant*

ILLINOIS DEPARTMENT OF PUBLIC AID

Increasing caseloads and rising costs for goods and services—particularly medical—have characterized Public Aid activities in the 75th Biennium ending June 30, 1969. These upward trends are expected to continue during the 76th Biennium, July 1, 1969, through June 30, 1971. Mounting expenditures have caused serious deficits in the appropriations for Aid to Families with Dependent Children, Disability Assistance, Medicaid (sometimes called Medical Assistance), and General Assistance to include Local Aid to the Medically Indigent—in all, \$110 million.

Projection of only one of the trends, rising caseloads, shows that in the federally-aided programs—Aid to Families with Dependent Children, Assistance to the Aged, Blind or Disabled, and Medical Assistance only—the caseloads of 413,000 persons in fiscal 1968 is expected to reach an estimated 451,000 in fiscal 1969, 490,100 in 1970, and 528,000 in 1971.

The Department began the 75th Biennium with an appropriation of \$763.6 million for distributive expenses, of which \$329.2 million—or 43%—was for medical assistance. Payments for basic maintenance items—food, clothing, housing, etc.—totaled \$354.4 million, \$108.4 million being for Assistance to the Aged, Blind, or Disabled and \$246.1 million for Aid to Families with Dependent Children.

Prior to September 1966, the state had only state funds with which to meet its responsibility to needy persons aged 65 and over who were patients in state institutions. Beginning with the 75th Biennium, changed policy and procedures enabled the state to channel into the Public Aid appropriation the costs of their care and that of certain other medically needy persons. Channeling these medical costs qualifies the state to receive federal funds on a 50/50 matching basis. Thus, while the appropriation to the Department of Public Aid had to be increased by a significant \$109.5 million, the state is gaining many millions of dollars in federal funds. It is important to note that in this instance Public Aid's responsibility is principally financial and consultative while administration and the provision of medical care and services remain the responsibility of the state agency of primary interest.

These needy and newly eligibles are: persons aged 65 and over in state mental institutions (Department of Mental Health); recipients of care from the Illinois Eye and Ear Infirmary (Department of Children and Family Services); children in certain foster care settings (under the supervision of the Department of Children and Family Services, or the Cook County Department of Public Aid); needy persons who receive care from the Illinois Research Hospital of the University of Illinois; needy persons aged 65 and over in state tuberculosis hospitals (Department of Public Health); and needy persons who receive goods or services from the Division of Crippled Children (University of Illinois).

Prior to the advent of Title XIX (Medical Assistance) on January 1, 1966, and Title XVIII (Medicare) on July 1, 1966, there were consistent rises in medical and hospital costs. After the advent of the two programs the rises have been much sharper. Medical costs in the 75th Biennium have risen and are projected to rise in the 76th. The increases are due to several factors, one of the more obvious being the rising caseload. Other reasons are: hospital costs have risen more sharply than anticipated; medical fees and rates have increased; there is greater utilization of medical services by those eligible to receive them.

The 75th Biennium saw an improvement in physicians' fees and a more efficient way for the physician to bill the Department and to receive payment. Since January 1, 1967, physicians have billed the Department in Springfield direct, citing their "usual, customary, and reasonable fees."

The usual, customary and reasonable fee concept for physicians was worked out in cooperation with the Illinois State Medical Society. It replaced the former flat fee system and brought payments in line with going rates. Payments to physicians in the aggregate have averaged about 92 percent of the charges as billed.

The billing/payment system is closely geared to automation, and some billing problems have arisen causing delay of payments in a number of instances. The delays usually stem from imprecisions in billing—incorrect or missing case identification data, patient ineligibility, AMA Procedural Terminology Code either missing or incorrect, incorrect procedure when the case involves Part B of Medicare, etc. Any such imprecision is cause for rejection by the computer and subsequent delay while corrections are sought. Initially there were problems involving duplicate billings—caused when a bill was withheld temporarily pending correction for payment and the physician re-billed the following month. These extra billings brought extra communications to obtain reimbursement. Now the computer is programmed to reject duplicate bills—another improvement.

Currently, nearly 100,000 physicians' bills are being processed monthly. Between 12 and 14 percent of the bills, on the average, are initially rejected because of procedural error or other imprecision. In progress is an educational program on billing procedures, sponsored jointly by the Illinois Department of Public Aid and the Illinois State Medical Society. Included in the program are an on-going series of articles in the *Illinois Medical Journal*, regional meetings with groups of physicians, direct mail, and telephone communications.

The usual, customary and reasonable fee concept was extended to dentists in April, 1967. Subsequent experience shows that as a result dental costs have increased about 80 percent. Comparably, payments to physicians rose about 100 percent. Payments to physicians (excluding General Assistance) amounted to \$5.7 million in calendar year 1966, \$10.0 million in calendar year 1967, and \$15.8 million in calendar year 1968.

Another factor in rising medical costs is the so-called cost-of-living growth—amounting to about six percent per annum—which is being experienced in physicians' services and dentists' services. Therefore, the Department is considering a six percent addition to base costs for fiscal years 1970 and 1971. Discussions are underway with the Fees Committee of the State Medical Society to determine the appropriate and effective way to improve payments, within the limitations of the six percent factor.

In April, 1967, optometrists were brought into the usual, customary and reasonable concept for professional services, but not for optical goods which remain on a formulary basis. The criteria for participation in the eye care program included optometrists who were practicing in so-called "commercial" settings. Since April, 1967, experience has shown that refractions continue at about the former level of 6,000 per month but the average payment per refraction has increased nearly 100 percent. Currently, it is estimated that these adjustments will result in a net increase of about \$400,000 in fiscal 1969, and that costs will rise as a result of cost-of-living increases—affecting both goods and services—by \$130,000 in fiscal 1970 and another \$160,000 in 1971.

Payments to podiatrists amounted to a bit less than \$70,000 in the 74th Biennium, and are estimated at \$105,000 in the 75th and \$206,000 in the 76th. The latter figure provides for some expansion in program content and consideration will be given to anticipated cost-of-living increases. Podiatrists have been using the usual, customary and reasonable fee concept for professional procedures since January, 1968.

Drug costs continue to edge upward despite the presence of an established drug formulary. An upward adjustment is proposed amounting to five percent in

fiscal years 1970 and 1971. Also, the fee component of the drug pricing formula possibly may be increased from the current \$1.20 to \$1.30 in fiscal 1970, and to \$1.35 in fiscal 1971.

General Hospital in-patient care is expected to increase 15% in fiscal years 1969, 1970, and 1971. Also, since out-patient services and clinics are tied to general hospital operations, it is estimated that clinic out-patient costs will also rise 15% in the same fiscal years.

Preventive medicine is a recurring topic for consideration. Desirable as such services may be, any proposal for substantial increases in this area must be weighed realistically with the hard fact of available dollars. Illness, disability, or limited physical capacity not only contribute to partial or full dependency but also cause misery and suffering which cannot be calculated in dollars. To date, the Department's experience in preventive medical care for needy children has been limited to payments of immunizations and physical examinations of school children at the intervals prescribed by law. The tight money outlook seems to indicate that preventive medicine will not be extended during the next biennium. Preventive medicine may be more appropriately a function of the Illinois Department of Public Health and is a subject of discussion.

Even if there were sufficient money and will to fully implement a preventive medical care program, there are other serious obstacles which would greatly impair such effort. Foremost reason is that there are too few doctors. Not long ago, the president of the Illinois State Medical Society commented on the shortage of doctors in Illinois, saying in part:

There are 14,000 licensed physicians in Illinois, but only 10,000 of them treat patients. The others are in medical school facilities, in private industry, or doing research. About 200 communities need doctors: in some communities there are no doctors, others need more. Pulaski County has one doctor for 2,522 people. Cities have problems, too: the Oakwood-Kenwood area in Chicago has five doctors—where once there were 40.

Five medical schools in the state are turning out fewer doctors today than they were in 1936. Most of the graduates will specialize; the general practitioner is becoming extinct, despite the fact that the state could use 10,000 general practitioners.

Many doctors prefer to stay near the metropolitan areas because they are specialists, and there isn't enough need for their special skills in small communities; because they believe the monetary returns are generally better there; and because of more conveniences and more attractions in metropolitan areas.

Estimated Medical Costs July 1, 1969—June 30, 1971

As of February 1, 1969, estimates indicate that \$514,364,000 will be required to meet the medical needs of eligible persons during the 76th Biennium covering the period July 1, 1969, through June 30, 1971. Approximately \$486,852,000 is for use in the Title XIX (Medicaid, sometimes referred to as Medical Assistance) program with federal participation at 50 percent; the comparable figure in the 75th Biennium is an estimated \$330,106,000. The remainder—an estimated \$27,512,000 in state money—is for medical expenses incurred in the General Assistance units which require state funds to supplement local General Assistance levies.

Expressed in percentages, medical expenditures are ex-

pected to increase about 48% over those in the 75th Biennium. About 25% of the increase is attributed to increasing costs of medical goods and services and about 18% to increasing numbers of persons who will receive medical care.

Much of this report is couched in terms of a biennial appropriation, long the traditional form in Illinois. Very recently (too late for inclusion in this report), the Department was asked to recast its requirements in terms of an annual appropriation.

Some of the data in this report are stated in annual terms such as for fiscal year 1970 and fiscal 1971. However, readers are cautioned not to attempt to convert overall 76th Biennium figures into an annual figure simply by dividing certain totals by two. The overall figures cannot be halved along annual lines because the continued projection of increasing caseloads, costs and utilization cumulatively result in higher totals in fiscal 1971 than in fiscal 1970.

Harold O. Swank, *Director*

Scientific Program

Highlights . . .

Monday

ILLINOIS SURGICAL SOCIETY
ILLINOIS OBSTETRICAL & GYNECOLOGICAL SOCIETY
SYMPOSIUM ON ALCOHOLISM
SECTION ON NEUROLOGY & PSYCHIATRY
SECTION ON SURGERY

Tuesday

SECTION ON ALLERGY
SECTION ON OBSTETRICS AND GYNECOLOGY
SECTION ON PHYSICAL MEDICINE & REHABILITATION
SECTION ON PREVENTIVE MEDICINE & PUBLIC HEALTH
CONTINUING EDUCATION PROGRAM IN PSYCHIATRY
SYMPOSIUM ON PERIPHERAL VASCULAR DISEASE
SECTION ON RADIOLOGY

Wednesday

SECTION ON E.E.N.T.
SECTION ON PATHOLOGY
SECTION ON PEDIATRICS
SECTION ON DERMATOLOGY
SECTION ON INTERNAL MEDICINE
SYMPOSIUM ON LEARNING AND READING PROBLEMS
TRAVELING SEMINAR ON ECFs AND HOMES FOR THE AGED
ILLINOIS SOCIETY OF INTERNAL MEDICINE
WORKSHOP ON PRACTICE MANAGEMENT

This 3-day program is acceptable for 24 elective hours by the American Academy of General Practice.



PUBLIC RELATIONS

Council on Public Relations

The Council on Public Relations met three times during the past year. It concerned itself principally with three areas: (A) ISMS Membership Survey on Socio-Economic problems; (B) the ISMS stand on liberalizing the Illinois abortion law; and (C) a joint statement on nurses' responsibilities in acute cardiac care cases. These and other Council projects are reviewed in the following committee reports.

Thomas R. Harwood, *Chairman*

Max Klinghoffer

Julian W. Buser

Matthew B. Eisele

Robert S. Mendelsohn

Henry A. Holle

James D. Majarakis

W. I. Taylor

Edwin A. Lee

ADVISORY COMMITTEE TO INTER-PROFESSIONAL GROUPS

During the past year, the Advisory Committee to Inter-Professional Groups concerned itself primarily with the work of the Illinois Interprofessional Council of Health Professions and the Illinois Association of the Professions.

Interprofessional Council

Committee members attended monthly dinner meetings of the Inter-professional Council of the Health Professions and participated in discussions of mutual importance to all professions represented.

The council consists of representatives from the Illinois Dental Society, Illinois State Veterinary Medical Association, Illinois Podiatry Society, Illinois Optometric Association, Illinois Pharmaceutical Association and ISMS. Combined membership of these organizations totals 50,000 members.

In accordance with action taken by the Board of Trustees in January, 1969, ISMS terminated its membership on the Interprofessional Council, but encourages individual memberships in the organization.

The committee will continue to provide liaison, as needed, with other health professions.

Illinois Association of the Professions

The Illinois Association of the Professions is a non-profit organization, incorporated under the laws of Illinois on February 6, 1964. Several other states have organized such associations with the same basic structure and purpose.

The IAP meets as a corporate body every three months and, on October 11, 1968, held its fifth annual meeting.

During the past year, IAP tackled such problems as professional services to the underprivileged (medical, legal, housing and public aid); professions in a modern world; the employed professional; and increasing professional productivity.

The board of directors concerned itself with the coming Constitutional Convention (Con-Con) and suggested that delegate selection be made on a non-partisan basis. Tax legislation for individuals and on services rendered also is under study.

A public relations program, including television programming, is being developed. Information pertaining to IAP appears in the individual professional journals each month. An accelerated promotion for individual memberships has been initiated.

ISMS representatives on the IAP Board of Directors are Drs. George B. Callahan, Edward A. Piszczek and Eugene L. Vickery.

The Chairman of the Advisory Committee to Inter-Professional Groups commends all members who have participated with enthusiasm throughout the year.

This report is for information only and requires no action.

James D. Majarakis, *Chairman*

Lawrence J. Bowness

George B. Callahan

Walter J. Reedy

Eugene L. Vickery

David Whitsell

Consultants

Andrew J. Brislen

Caesar Portes

E. A. Piszczek

ADVISORY COMMITTEE TO PARAMEDICAL GROUPS

The ISMS Advisory Committee to Paramedical Groups reports continued cooperation with the Illinois Medical Assistants Association and the Health Careers Council of Illinois. This committee was relieved of activities with the Student AMA by transfer of these functions to the Medical Education Council.

At a meeting of this advisory committee early this year, the committee unanimously favored continuing ISMS support for the Illinois Medical Assistants Association. The committee believes it should increase its efforts to encourage state physicians to promote IMAA membership for their individual medical assistants. The committee seeks to include IMAA promotion during appearances by the ISMS President and President-Elect before County Medical Society groups.

The ISMS staff and the advisory committee have given counsel, professional assistance and part time secretarial help for the following IMAA activities:

- 1) Editing, publishing and distributing the monthly "Executive Memo" with the cooperation of IMAA President, Mrs. Helen Smith.
- 2) Preparation of news releases regarding the annual convention, educational symposia and training seminars.
- 3) Editing and publishing reports and articles in the *Illinois Medical Journal* and *Pulse*.
- 4) Printing the officers and committee chairmen annual reports, council meeting minutes and special promotional pieces.
- 5) Assisting in the publication of the IMAA Quarterly Newsletter.

As in the past, IMAA has reimbursed the society for a portion of such expenditures as secretarial services, paper, printing and plates used in IMAA projects. Services provided by the society's staff are available without charge. The Public Relations Director serves as staff coordinator for all IMAA projects channeled through the society.

During the past year the chairman and various committee members attended IMAA council meetings and educational meetings and gave assistance when requested.

The committee believes the ISMS projects on behalf of IMAA help to promote a worthwhile relationship between the organizations. Future implementation of existing programs and newly-developed programs should sustain and enhance this relationship.

Activity by the Health Careers Council of Illinois has necessitated no actions by this committee.

The Chairman commends all Committee members who have participated with enthusiasm and creativity throughout the year.

This report is for information only, and requires no action by the reference committee.

Thomas R. Harwood, *Chairman*

Allison Burdick, Jr.	Robert E. Lynn
Burton M. Krimmer	William Mohlenbroch
Edward J. Krol	Maynard I. Shapiro
Paul G. Theobald	

Consultants:

Carl E. Clark	James B. Hartney
Casper Epsteen	E. A. Piszczek
Mrs. John W. Koenig,	<i>Auxiliary Representative</i>

COMMITTEE ON DISASTER MEDICAL CARE

The major emphases of the Committee on Disaster Medical Care during the past year continued to be in the following areas: Packaged Disaster Hospitals; ambulance service problems; medical care problems stemming from civil disorders and intermediate disasters.

Packaged Disaster Hospitals

The committee helped train over 600 people at seven PDH training sessions in Elmhurst (4), Springfield (2), and Chester (1). Activation of the Chester PDH program brought to realization the committee's 1968-69 goal of establishing three such training centers in the state.

Intermediate Disasters

At the 1968 House of Delegates session, the committee introduced a resolution expressing the feeling that—during disasters—"hospitals must represent a type of sanctuary and that all medical personnel must be free to treat patients without fear of injury to themselves or damage to the facilities in which they work" The committee is pleased to report that the resolution was passed by the ISMS House of Delegates, the AMA House of Delegates, and the Illinois State Senate. Another committee resolution to be placed before the ISMS House of Delegates at this session will urge cooperation of Illinois hospitals and medical staffs in placing and storing Packaged Disaster Hospital and Natural Disaster Hospital units, and in training persons to staff them.

Disaster Manual For Hospitals

The ISMS Disaster Manual for Hospitals—produced by the committee in cooperation with the U.S. Public Health Service in 1965—is being revised for distribution later this year. New materials on the Natural Disaster Hospital and revisions of existing sections will be included in the new manual.

The original disaster manual was distributed to more than 1,000 hospitals and disaster planning units throughout the U.S.

Meetings

The committee held two meetings and phone conferences during the year. In addition, the chairman attended the AMA Conference on Disaster Medical Care in Albuquerque, N.M. (Nov. 1968), and the U.S. Civil Defense Council (Oct. 1968) in Milwaukee, Wis.

Committee members also addressed various nurses, police and fire groups, individual hospitals, and the American Hospital Association, U.S. Public Health Service, National Safety Council, and U.S. Civil Defense Agency meetings.

Sub-Committee on Ambulance Service

This sub-committee serves as the official ISMS delegation to the Ad Hoc Emergency Health Services Study Commission. The delegation—consisting of Max Klinghoffer, M.D., Harold Lueth, M.D., Colman O'Neill, M.D., James Kurtz, M.D., and William Hark, M.D.—attended four meetings of the Commission during the past year.

While its title implies coverage of a broad spectrum of activities pertaining to emergency health services, the Commission has directed most of its efforts to ambulance service problems.

Late in 1968 the Commission studied several legislative proposals dealing with ambulance service problems and referred them to a sub-committee for revision prior to introduction in the Illinois General Assembly. Any

legislation proposed will be screened by the ISMS Legislative Council prior to a position being offered by the ISMS delegation.

The Chairman of the Committee on Disaster Medical Care commends all committee members who have participated with enthusiasm through the year.

This report is for information only and requires no action by the reference committee.

Max Klinghoffer, *Chairman*

Jack R. Baldwin

William A. Hark

Harold C. Lueth

Carl Steinhoff

Charles F. Sutton

COMMITTEE ON NURSING

In its efforts to maintain the best possible inter-professional relations between the nursing and medical professions, the Committee over the past year concentrated on the ever-growing problem of dependent nursing functions.

Emergency Cardiac Care

The Committee met with representatives of the Illinois Nursing Association, Illinois Hospital Association, and Chicago and Illinois Heart Associations to draft a joint statement with regard to nursing training and supervision in hospital emergency cardiac care units.

At this meeting, a statement was drafted which met with the approval of the legal counsel of the involved groups. Essentially, the statement called for training and supervision of nurses for emergency cardiac unit service to be administered by a medical staff cardiac care committee in each hospital.

While the ISMS Committee on Nursing and Board of Trustees approved the statement, objection was raised by some of the other groups as to the qualifications of individual hospitals to adequately administer such supervision and training. Consequently, this Committee submitted to the ISMS Board of Trustees a similar statement omitting the names of the other associations. The Board accepted it at its March 8, meeting.

Administration of Narcotics

Pending decision of ISMS' legal counsel, the Committee approved the recent suggested amendment to the Uniform Narcotics Act which would, in effect, permit licensed practical nurses as well as registered nurses to administer narcotics under the supervision of a physician. This position is in accord with that of the Illinois Nurses' Association and, it is hoped, provides substantive assistance to ISMS legislative efforts on this matter.

Administration of Intracaths

Late in 1968 the Committee received correspondence from a registered nurse concerning the legality and medical ethicalness of intracath infusion by nurses. It was the Committee's decision that this situation was referable to the Joint Statement on Dependent Nursing Functions which states that ultimate responsibility for the nurse in such functions rests with the hospital which employs her. Pending the decision of legal counsel, reply to the correspondence received will be made along these lines.

Other Dependent Functions

With regard to the role of the nurse in administering experimental drugs, anesthesia in obstetrics, and other dependent functions, the Committee undertook vigorous exploratory action using as guidelines a joint position state-

ment on these issues by the New York medical, hospital and nursing groups.

Because of the great complexity of these decisions—and the many factors involved in making them—final recommendations are being deferred and will comprise a major segment of Committee activity in the forthcoming year.

The Committee extends its gratitude to the Illinois Nurses' Association, Illinois Hospital Association, Illinois and Chicago Heart Associations and many other groups whose cooperation and active participation over the past year have contributed significantly to the resolution of issues affecting the medical and nursing professions.

W. I. Taylor, *Chairman*

Raymond Firfer

Roger Sondag

H. J. Kolb

Luke R. Pascale

Willard C. Scrivner, *Consultant*

Mrs. Mitchell Spellberg, *Auxiliary Representative*

COMMITTEE ON HOSPITAL RELATIONS

The Committee on Hospital Relations met twice during the year and made strides in several areas—particularly in public relations projects involving Emergency Rooms and Utilization Review.

Utilization Review

To help Utilization Review function more efficiently and effectively, the committee co-sponsored a UR workshop in Rockford with the Illinois Hospital Association. Some 54 physicians, hospital-administration personnel and medical record librarians attended.

In any further workshops co-sponsored by the committee, the Medicare carriers for Illinois—Continental Casualty and the Blue Shield Plan of Illinois Medical Service—will be invited to play an active role because of their stake in UR.

ISMS Membership Survey Questions

Utilization Review also is the subject of one of the 1968 ISMS Membership Survey questions referred to the committee by the Board of Trustees. The question was: "Should the authority of UR committees be increased to eliminate unnecessary hospitalization?" Our committee endorsed such action. As a preliminary to further steps, however, it wants to determine the legal immunity of physicians serving on UR committees.

On other questions from the August survey, our committee voted to give "moral support" to the idea of a 7-day hospital week. It endorsed mandatory areawide planning for capital expansion and specialized needs of hospitals. But it felt it had no specific recommendation to make on areawide consolidation of purchasing, laundry, etc.

Emergency Rooms

The committee thinks one of the most significant measures it can take is to discourage the overuse of hospital Emergency Rooms—and the costliness to both hospital and patient. Reviewing 40 pages of staff-compiled research, it found that ER treatment often costs the patient twice as much as comparable treatment in a doctor's office.

Two pamphlets are being prepared under committee auspices. One will be beamed at patients, and emphasize ER cost to them. The other will be directed to physicians, asking them to avoid non-emergency referrals to ER rooms and to arrange for alternate MD coverage of their private cases when they are unavailable.

The committee hopes to get the greatest possible mileage out of these pamphlets, including free reproduction as public-service ads in newspapers.

This report is for information only and no action is required by the reference committee.

J. W. Buser, *Chairman*

John A. Bowman
Caesar Portes

Kenneth John Smith
Harlan English, *Consultant*

COMMITTEE ON PUBLIC SAFETY

The Committee on Public Safety held four meetings during the past year with the major part of its activities devoted to safety legislation.

Legislative Items

Meetings were held with representatives of the Illinois Department of Public Health, Secretary of State's office, Illinois State Police, and legislative leaders to help refine key pieces of safety legislation. Many hours were devoted to redrafting two bills: (1) The Implied Consent Bill for testing suspected intoxicated drivers; (2) The Medical Advisory Board Bill to assist the Secretary of State in determining when an individual's physical or mental condition might impair his driving abilities.

Medical Aspects of Air Travel

Another item considered by the committee is the proposed compilation of a new list of medical conditions which might make air travel inadvisable for passengers. If the study reveals a definite need for such a list, the committee will propose publishing a booklet for distribution to Illinois physicians as an aid in advising patients.

Other Areas of Interest

Other matters reviewed by the committee include:

- 1) Encouraging wider use of automotive safety belts
- 2) Continued cooperation with the Accident Crash Injury Research of Cornell University.

The committee expresses its appreciation to Col. Dan L. Smith, Illinois Department of Aeronautics, and Mr. James Dickroeger, Illinois Department of Public Health, for their valuable assistance.

The chairman commends all committee members who participated with enthusiasm throughout the year.

This report is for information only, and requires no action.

Edwin A. Lee, *Chairman*

James P. Campbell
Julius M. Kowalski

Donald S. Miller
Norman J. Rose

Clifford P. Sullivan

Mrs. Arthur Smith, *Auxiliary Representative*

MEMBERSHIP COMMITTEE

The Committee is pleased to announce completion of a major project in 1968—the ISMS Membership Booklet.

This smart-looking, 24-page booklet contains a summary description of ISMS programs and benefits aimed specifically at attracting new members. It also serves as a handy, easy-to-read guide for all ISMS officers, members and staff.

"Premiered" at the Board of Trustees meeting in January, 1969, the booklet was enthusiastically received as a much-needed summary of activities that will be of practical value to anyone associated with, or interested in, ISMS.

To assure optimal exposure of the 3,000 copies made available in the first printing, the booklets were distributed to:

- 1) The president, secretary, and membership committee chairman of each county medical society
- 2) All ISMS officers and Board members
- 3) All delegates and alternate delegates to ISMS
- 4) All newly-licensed physicians in Illinois (This distribution will continue as additional names are obtained from the Department of Registration and Education.)
- 5) All residency physicians in Illinois.

In addition, order coupons for the booklet will appear regularly in 1969 issues of the *Illinois Medical Journal* and *Pulse*.

The committee plans to initiate a concerted membership drive based around the booklet involving:

- 1) Procurement of the membership list of the Illinois Association of Resident Physicians. Each non-member on this list would be sent a booklet and solicitation letter.
- 2) Each county medical society will receive a letter from the committee encouraging it to establish a membership committee. These committees will be asked to invite small groups of non-member physicians and their wives to a "get acquainted" meeting. The booklet will be made available for distribution at such meetings.

While printing and production for the ISMS Membership Booklet virtually depleted the committee's budget for the year, we are confident that this expense is justified in terms of the results it will achieve in gaining new members—and new friends—for ISMS.

The committee wishes to express its appreciation to the Public Relations Division for its technical and creative assistance in the preparation of this booklet.

Henry Holle, *Chairman*

Joseph N. Bourque

Andrew J. Sullivan

Burton J. Soboroff

H. Close Hesselstine, *Consultant*

Mrs. Sherman Arnold, *Auxiliary Representative*

COMMITTEE ON PUBLIC RELATIONS

While continuing its popular health education features, the Public Relations Committee shifted its emphasis the past year to membership and socio-economic programs.

Its biggest programs in this area were: (1) The Membership Survey on Socio-Economic Issues; (2) The President's Tour; (3) Government Health Program Workshops; (4) Practice Management Programs.

Membership Survey

Each year, ISMS is faced with an increasing number of legislative and socio-economic problems, such as demands for liberalized abortion laws . . . physician shortage . . . rising health costs.

To learn the membership's views on such issues, the committee conducted a state-wide membership survey. The study—underwritten by the *Illinois Medical Journal*—was conducted to: (1) give physicians a greater voice in ISMS policy matters; (2) provide our officers with a better understanding of the membership's views; (3) update the content of the *Illinois Medical Journal*.

The survey proved extremely successful, as more than 3,000 physicians responded.

The tabulated results were released to the press, radio and television—providing ISMS with a wealth of favorable publicity—and analyzed for our members in a three-part *IMJ* series. They provided ISMS with an important

programming guide and proved valuable to our President and President-Elect in their meetings with the press on their President's Tour.

President's Tour

President's Tour 1968-69 was an exhausting, cross-state tour by our President and President-Elect of ISMS to districts and county medical societies.

Its purpose? To tell "the ISMS story" and exchange views on important legislative and socio-economic matters with grass roots members and community leaders.

In doing so, President Philip Thomsen and President-Elect Edward Cannady addressed over 1,000 physicians and their wives in district-wide meetings at Rockford, Carbondale, Alton, Joliet, Moline, Champaign, Springfield and Effingham. They also addressed physician groups in Peoria, Sycamore and various Chicago Medical Society branches.

In addition, they talked to over 800 community leaders, appeared on 17 radio and 10 television programs, and had more than 100 news stories published in the Illinois press.

A vital part of the newly-expanded President's Tour was the Workshop on Government Health Programs.

Workshops on Government Health Programs

To help physicians and medical assistants understand the intricacies of government health programs—and assist them in prompt collection of usual, customary and reasonable fees—the committee organized a Workshop on Government Health Programs.

The workshop, which traveled across the state as part of the President's Tour, is a four-hour program featuring authoritative speakers from Medicare, Public Aid, Vocational Rehabilitation, Children and Family Services, and CHAMPUS.

Using visual aids, the speakers show how to cut through government red tape . . . complete health forms properly . . . avoid common errors . . . and simplify work with respect to complicated government health programs.

More than 1,500 physicians and medical assistants attended the 12 workshops which were put on in every city covered in the President's Tour, including three in Chicago.

Each participant received a valuable workbook on government health programs which was compiled by ISMS staff and underwritten by Blue Shield Plan of Illinois Medical Service.

Journalism Fellowship

The committee's successful Medical Journalism Fellowship program continued in 1968 with the naming of Reporter James Rick, *Danville Commercial-News*, and Reporter Sue Dinges, the *Illinois State Register*, as recipients.

The fellowships—presented to promising news reporters interested in medical writing—was established in 1967 to train newsmen in medical writing and increase coverage of medical society news by non-metropolitan newspapers.

As recipients, Mr. Rick and Miss Dinges participated in an intensive four-day workshop at the ISMS' annual meeting. Throughout the program they followed a rigid agenda which exposed them to every phase of convention activity. The reporters attended reference committee hearings, scientific programs, and the House of Delegates sessions, as well as working in the press room.

Medical Journalism Awards

To acknowledge outstanding achievements in medical journalism—and stimulate improved radio-TV-newspaper coverage of medical events—the committee conducted its fifth annual Medical Journalism Awards program.

The program, which has received wide acclaim, attracted over 130 entries, which were judged by a panel of experts provided by the Publicity Club of Chicago. Assisting them were Drs. Matthew B. Eisele, Lee Winkler, Charles Vil, William Harridge, Paul Sunderland, and Catherine Dobson.

Honored at a special March 8 Awards Dinner were: Television Stations WHBF (Rock Island), WMAQ and WBBM (Chicago); Radio Stations WKRS (Waukegan), WBBM and WGN (Chicago); Newspapers "Chicago Daily News," "Chicago Tribune," "Chicago's American," "Hinsdale Doings," "Rockford Register-Republic," Danville "Commercial News," Elgin "Daily Courier-News."

Radio and Television

Again ISMS compiled over 500 hours of public service broadcast time—or 22 full days of airtime—during the past year.

While much of it came through personal appearance on radio and TV by ISMS officers and committee chairmen, the bulk of it was compiled on programs produced and distributed by ISMS itself. They included:

● *Dr. SIMS Radio Health Tips*—These daily, 30-second practical health tips were aired over 30,000 times by 59 radio stations throughout the state.

● *Medical Interview*—This weekly five-minute discussion show was aired regularly on 42 different radio stations throughout the state.

● *One-Minute TV Spot*—Our lone TV public service spot, on pre-school physical examinations and immunizations, was telecast on all of the state's 25 television stations last summer and fall.

Newspaper Features

One of the most important aspects of our health education is the work done by Dr. Charles J. Weigel, who reviews and edits our Dr. SIMS newspaper features—"Dr. SIMS Says" and "Dr. SIMS Talks to Teens."

The "Dr. SIMS Says" health tips—supplied to publications in mat and reproduction proof form—is published in 27 daily newspapers and weekly in 10 other newspapers.

The "Dr. SIMS Talks to Teens"—also supplied in mat and reproduction proof form—is published in over 320 high school newspapers.

Because of increasing demands for the old "Dr. SIMS Says, Safeguard Your Health" column—which was discontinued in 1968 after six years of publication—the committee is planning to re-issue the weekly feature early this summer.

State Fair

For the fifth consecutive year, Dr. SIMS maintained an "office" at the ISMS exhibit during the 1968 State Fair in Springfield. Dr. SIMS—portrayed by a representative of the PR staff wearing a three-foot high plasticized head—participated in the opening day parade and again attracted record-breaking crowds to the ISMS exhibit.

Parents and children alike shook hands with the ISMS symbolic emissary in what amounted to the most successful state fair promotion in ISMS history. Dr. SIMS proved

an ideal good-will ambassador as he distributed to youngsters some 10,000 balloons bearing the image and health message of Dr. SIMS and the Illinois State Medical Society. In addition, volunteers from the Sangamon County Woman's Auxiliary distributed over 6,000 packets of health information materials to adults.

Fifty Year Club

The ISMS Fifty Year Club added 42 physicians to its roster in 1968, bringing its membership to 503. Another 75 doctors are expected to be admitted this year.

The highlight of the year was its Sesquicentennial Luncheon held in conjunction with the ISMS annual meeting in Chicago. Dr. W. D. Snively, vice president for medical affairs at Meade Johnson in Evansville, Ind., was the featured speaker, with Dr. Lee Winkler—a member of the ISMS Public Relations Committee—presiding.

At the luncheon, ISMS President Dr. Newton DuPuy presented Fifty Year Club certificates and lapel emblems to 12 Chicago Medical Society members and accepted a certificate from Dr. Ralph Newman—chairman of the Illinois Sesquicentennial Commission—for the profession's 150 years of medical service to the state.

The 1969 luncheon meeting of the club is scheduled May 20 in conjunction with the ISMS annual meeting at the Sherman House, Chicago.

Matthew B. Eisele, *Chairman*

William H. Harridge

Charles J. Weigel

Charles SiVil

Lee F. Winkler

Consultants

Jacob E. Reisch

Paul W. Sunderland

Leo P. A. Sweeney

Physicians Placement Service

ISMS has included the Physicians Placement Service as one of its services to members for the past 24 years. In preparing this annual report the placement service secretary, who has served in this capacity since its inception, has reviewed the annual reports for each year and notes that the objectives continue to be as outlined in the beginning: 1) to assist physicians in finding desirable locations in which to practice; 2) to assist communities in finding physicians.

Since the last annual report, the service has been directly responsible for placing 19 physicians (one less than last year). There is good reason to believe that other placements have been completed and have not been reported by either the community or physician, as this is the case each year. Also, in looking over the list of new downstate members of ISMS, we note many names that have appeared on our placement service mailing list. Even though these new members have not located in the towns suggested, many of them have at least opened offices in larger nearby towns and thereby help to serve the areas where the need was reported.

As a direct result of our efforts, general practitioners have located in the following areas: two in student health centers, six in offices of Cook County physicians seeking associates, one in the Internal Revenue office of Chicago, one in an insurance company and one in Lake County. Specialists have been placed in the following counties: Rock Island, Kane (two openings filled), McHenry, Lake, Champaign, Ford and Jackson.

The number of placements completed has been approximately the same during the last several years. The

trend is very discouraging when compared to the increased efforts given the project and when comparing it to the placements made in the early years of the placement service. However, when we consider the nationwide trend toward specialization and the resulting location of physicians in the metropolitan areas rather than in the rural areas—which have always been the first responsibility of the placement service—we feel our report is no doubt as favorable as that of other state medical societies. We are in constant touch with the Physicians Placement Service of the AMA and are advised that the services of the other societies are having identical problems.

During the past year we have had a total of 606 physicians on our mailing list, as compared to 700 the previous year. While 292 still receive our notices of openings, some 314 have been removed because they have either found suitable locations or have neglected to reply to our follow-up letters. New names to be added are received from the AMA Placement Service each month and others come directly to our office.

The Michigan Health Council—in cooperation with the Michigan State Medical Society—has received considerable publicity in recent months in the AMA News and elsewhere as a result of their placement service activities. As a result, arrangements were made for our secretary to visit the office of the health council in January of this year. She found the visit most rewarding and came away with the greatest respect for this efficiently operated office. Most of the procedures were identical to the ones being carried out in our own office, although in Michigan one employee works full time on placement activities, and three others devote considerable time to this area.

Since the first of the year we have made a special effort to secure the lists of interns and residents from Illinois hospitals in an effort to interest them in registering with our Placement Service.

Early in February more than 1,300 letters were directed to this group, but as this report is being written (March 12) only 31 have returned the questionnaires enclosed. This is indeed discouraging, as we had hoped to increase our mailing list in this manner. But it is evidence that most newly licensed physicians of today are flooded with opportunities without seeking help from our placement service or other sources.

Since the last annual report a new brochure was made up and is forwarded to new registrants with the placement service. We feel it is a more sophisticated pamphlet than one used in recent years and is being well received.

COMMITTEE ON RELIGION AND MEDICINE

The Committee is pleased to report on a very productive year, as reflected in completion of the following activities:

"What Every Physician Should Know"

Compiled from one dozen articles published in the *Illinois Medical Journal*, a booklet entitled "*What Every Physician Should Know About the Religious Needs of His Patients*" was published under the direction of the Committee's IMJ Articles subcommittee, Dr. J. Ernest Breed, chairman. In addition to being distributed at the medicine-religion exhibit at the annual meeting, this handy compendium of medical-ethical issues was distributed to every medical society, nursing home and hospital throughout Illinois.

Copies were directed specifically to hospital chaplaincy services, administrators, and nursing education heads. In addition, the booklet was made available through order coupons in *IMJ* and *Pulse*, to which hundreds of Illinois physicians responded. At its annual clinical conference in the fall, the American Medical Association distributed copies of the booklet to medicine-religion committee chairmen from states throughout the nation, eliciting requests for it from more than a dozen out-of-state sources.

In all, the booklet proved so popular that its initial printing of 16,000 copies is almost depleted, less than one year after publication.

The Committee is grateful not only to Dr. J. Ernest Breed for his tireless efforts in directing the publication of this booklet and writing several of the articles, but also to the ISMS Journal Committee for financial support that made its publication and distribution possible.

At this writing, the American Medical Association plans a similar publication.

Radio Series

This 10-part, half hour series entitled, "Medicine, Morals and You," was completed and broadcast Sunday mornings on Chicago radio station WJJD. Covering such vital and topical issues as euthanasia, transplants, abortion, and the unwed mother, the dramatic-discussion series was received enthusiastically by many and is now available on loan basis to radio stations throughout the state.

Awards Program

Following a statewide solicitation which evoked a response of more than 50 entries, a Physician of the Year and Clergyman of the Year were selected by the awards subcommittee and formally honored at a program during the Board of Trustees dinner in Springfield, October 5. Mrs. Sherman Arnold, our Auxiliary representative, was the very capable chairman of this subcommittee. The award recipients were: Dr. Clement P. Cunningham, a Rock Island general practitioner, and Rev. Paul R. Surbey, pastor of St. John United Church of Christ, Granite City.

Both were selected for best applying religious principles in providing total patient care over the past year.

The award, which this Committee instituted to dramatize the need for closer cooperation in total patient care between physician and clergyman, is believed to be the first ever presented by a medical group and proved sufficiently successful that the Committee has recommended it as an official ISMS event.

Seminary Program

Following guidelines established by the American Medical Association, the Committee undertook initial steps in an instructional program for seminary students.

Beginning with seminaries in and peripheral to Cook County, the program will seek to enlist the help of physicians who will discuss, at the seminaries themselves, the management of patients likely to be encountered by members of the ministry in their future chaplaincy duties.

The Committee is hopeful that this program will help to establish more meaningful collaboration between physician and clergyman in the everyday care of patients, and has established a seminary subcommittee chaired by the Very Rev. Msgr. Armand J. Rotondi, who is also a physician.

This subcommittee has already held initial planning meetings with representatives from the CMS Medicine-Religion Committee, and the DuPage, Kane, Will-Grundy and Lake County medical societies to launch the program in these counties within the next year.

Annual Meeting Exhibit

Under the chairmanship of Dr. Anna Marcus, a religion and medicine exhibit appeared again at the Annual Meeting of the State Medical Society. It was manned by both physician members of the Committee and clergymen. There was remarkable interest shown by the Society membership as indicated by the number of persons visiting the exhibit.

Formation of Local Medicine and Religion Committees

Efforts to encourage the formation of medicine and religion committees at the county medical society level have continued. An outstanding achievement this year was the formation of such a committee by the Chicago Medical Society. The chairman of this committee is Dr. Warren Young.

Abortion, Insemination Issues

The Committee was called upon by the Board of Trustees over the past year to render its position on the proposed abortion and artificial insemination issues before the Illinois legislature. These positions were requested to aid the Illinois State Medical Society in determining its official posture in both of these controversial issues.

Our Committee sponsored a major public meeting during the Annual Meeting of the Society on May 19 entitled "Ethical Aspects of Abortion." This meeting was co-sponsored by the Catholic Physicians' Guild. Participants included The Rev. Charles Carroll of San Francisco, The Rev. Charles Corcoran of Dubuque, and Rabbi Martin Goldman of Chicago. Dr. Eugene F. Diamond served as moderator.

The presentations of these three speakers appeared in sequential issues of the *Illinois Medical Journal*.

In the view of this Committee, as expressed to both the Illinois State Medical Society Maternal Welfare Committee and Legislative Council, both issues are sufficiently complex in nature to justify more considered deliberations. Consequently, it recommended that the Society encourage and adequately support presentation, discussion and consideration of these issues, that may require a year, by county medical societies and other involved and interested bodies at the county level.

After the results of these considerations at the local level have been submitted to the Society, the Committee suggests that a resumé of each issue be made as a basis for further Society recommendations to the Illinois legislature.

Staff Aid

While the Committee is pleased with the quality of staff assistance provided, it feels that additional staff aid is essential to the effective implementation of its expanding area of programming. Consequently, it has recommended to the executive administrator of the Illinois State Medical Society that such additional assistance be provided.

In summary, the Committee is satisfied to have completed its schedule of comprehensive programs over the

past year designed to promote closer physician-clergyman relationships in achieving better patient care. Equally important, it is pleased to have been called upon to express its recommendations on matters that may affect the policies of the Society for many years to come.

Finally, the Chairman wishes to express his personal appreciation to the Committee members who have not only graciously accepted many responsibilities but, have also "religiously" carried them out.

Robert S. Mendelsohn, *Chairman*

Anna A. Marcus
Charles W. Pfister
Paul S. Rhoads
The Very Rev. Msgr.
Armand J. Rotondi

William H. Whiting
Rabbi E. H. Prombaum
Rev. John Marren
Rev. Christian Hovde

Consultants

J. Ernest Breed

Caeser Portes

Auxiliary Representatives

Mrs. Sherman C. Arnold

Mrs. John W. Koenig

Sunday, May 18
1:00 p.m.
Louis XVI Room

1969 Conference on Hospital Cancer Programs

Monday, May 19
9:00 a.m.
Ruby Room 113

Symposium on Alcoholism

Monday, May 19
4:00 p.m.
Gold Room 114

IMPAC Annual Meeting

Monday, May 19
6:00 p.m.
Bal Tabarin

Public Affairs Dinner & Camp Memorial Lecture

Tuesday, May 20
10:30 a.m.
Life Room 108

Symposium on Peripheral Vascular Abnormalities

Tuesday, May 20
12:50 p.m.
Old Chicago Room 101

Continuing Education Program in Psychiatry For Physicians in Private Practice

Tuesday, May 20
6:00 p.m.
Bal Tabarin

President's Reception and Dinner

Wednesday, May 21
8:30 a.m.

Traveling Seminar on ECFs and Homes for the Aged

Wednesday, May 21
1:00 p.m.
Ruby Room 113

Symposium on Reading and Learning Problems

Wednesday, May 21
1:00 p.m.
Louis XVI Room

Workshop on Financial Planning



Council on Scientific Services

The Council on Scientific Services has met twice since the last annual meeting of the Illinois State Medical Society and has reviewed the activities of the Committees on Alcoholism, Cancer Control, Child Health, Maternal Welfare, Mental Health, Narcotics and Hazardous Substances, Nutrition, Public Health, Radiation and Rehabilitation Services.

Several of these committees are very active and make important contributions to the state medical society. Others, unfortunately, have not been active, either because no items of business came to the committee's attention or because the committee simply did not meet.

In the area of addiction, the committees on Alcoholism and Narcotics have attacked the problems in their respective spheres with vigor. The Committee on Alcoholism has established a close working relationship with the Illinois Hospital Association and law enforcement officials in a mutual effort to establish detoxification centers for inebriates so that alcoholism can be effectively treated as the disease it is instead of a criminal offense. This committee looks forward to the time when Illinois can handle this widespread problem in the same enlightened way that it is handled elsewhere despite the recent adverse decision of the U.S. Supreme Court that imprisonment of alcoholics does not constitute cruel and unusual punishment.

The Council commends the Committee on Alcoholism and its dedicated members headed by Dr. Abraham Gelperin. It has recommended that this committee concern itself with both the legal *and* medical aspects of alcoholism and that an alliance be formed with the National Safety Council to consider recommending stiffer penalties for persons operating moving vehicles while under the influence of alcohol. The Council expressed deep concern over accidents caused by drinking drivers and suggested that the committee investigate controls imposed in other countries, notably Sweden. At the same time, the Council emphasized that the committee's interest in the management of the disease itself should not be minimized.

The Committee on Narcotics & Hazardous Substances has been concentrating on marijuana and psychedelic drugs following a national symposium it conducted on the subject last spring. The Committee has been disappointed in its attempts to have the papers from this symposium published. Despite a strong demand for copies of these papers, the committee, as of the time this report is written, has been unable to finance publication.

The committee feels that if members of the society

had attended the symposium or read the papers presented there, those responding to the membership survey of controversial socio-economic questions might have given a different response on the question of modifying penalties for marijuana possession. The committee pointed out, however, that despite the fact that respondents had no background on what modifications were contemplated, nearly half of them indicated they favored some change in the laws.

As a result of this response, and particularly on the basis of its own studies of the problem, the Narcotics Committee voted unanimously to support the State Narcotics Advisory Council's recommendation that the penalties for first offense possession of marijuana be reduced from a felony to a misdemeanor. The chairman, who has been extremely active in making the public aware of the drug problem, particularly with respect to young people, testified before the Illinois House Judiciary Committee in February and recommended that marijuana laws be modified. Although the committee has taken a strong stand in favor of lessening penalties for marijuana possession, it has emphasized that its activity in no way implies that marijuana is not harmful or that it favors permissiveness.

The Council commends the Child Health Committee and its chairman, Dr. Ralph Kunstadter, for keeping abreast of matters affecting children. The committee was active this year in securing Board of Trustees approval of a standardized school health examination form proposed by the Department of Public Health and is helping the Illinois Commission on Children push legislation for screening of hearing impairment in children. Two members of this committee, Dr. Kunstadter and Dr. Edward F. Lis, serve on the Commission, while Dr. Kenneth Nolan serves as its delegate to the Statewide Co-operating Committee for the 1970 White House Conference on Children.

Again this year, no items of business were referred to the Committee on Cancer Control and it may be that this committee should be discontinued. It has been pointed out to the Council that where there are voluntary health organizations, such as the American Cancer Society, Tuberculosis Institute, etc., having physician representation, it may not be necessary for the state medical society to maintain a standing committee for the same disease and that any items of business relating to such disease could be handled by the Council on Scientific Services or an ad hoc committee.

The Maternal Welfare committee, under the direction

of Dr. Robert R. Hartman, continues to investigate the causes of maternal deaths in cooperation with the State Health Department.

Last year, following the House of Delegates' refusal to take a position on the question of modifying Illinois abortion laws, the resolution in favor of modification was referred back to the committees on Maternal Welfare and Religion and Medicine. The chairmen of these committees met to make the following joint recommendation:

1. *The Committee on Maternal Welfare reaffirms its position that the current abortion law in Illinois be modified in accord with recommendations made by the American Law Institute.*

2. *The Committee on Religion and Medicine maintains that insufficient discussion has been generated and too little information disseminated on the subject. Consequently, it stands firm in its view that the matter be deferred and referred to county medical societies and other organizations for further deliberation, as specified in its meeting of December 4, 1968.*

3. *In a statewide poll taken in 1968, over 3,000 of 10,000 ISMS members replied to the abortion issue. Of these 3,000, approximately 73 per cent favored modification of the current law.*

4. *Concern is expressed by both Drs. Hartman and Mendelsohn that the state legislature may take action on the abortion law issue before medicine adopts a position of leadership.*

As this report is written, various proposals on changes in the abortion law are being introduced into the Illinois General Assembly, including a bill sponsored by The Family Study Commission, the appointment of which had a bearing on last year's House of Delegates' delaying action.

The Council deplors the lack of activity on the part of the Mental Health Committee which should be interested in the abortion question, the proposal to provide prisoners with psychiatric examination before parole, and other important subjects. It is hoped that the committee will be reactivated soon.

The Nutrition Committee co-sponsored two successful conferences during the year. The Council commends Dr. Paul Dailey and his committee for their dedication and enthusiasm and suggests that in addition to working with dietitians and other professional nutritionists, the committee become interested in public education to counteract the publicized widespread malnutrition that exists at all economic levels.

The Committee on Public Health is charged with liaison with the Illinois Department of Public Health and various aspects of its widespread operations. In addition to these assignments, it is recommended that the committee give increased emphasis to environmental problems, including water and air pollution, as well as noise, which is causing increasing incidence of deafness.

Two other committees reporting to the Council on Scientific Services—Radiation and Rehabilitation—have been having communications problems with state agencies, and the Council has recommended that the Board of Trustees request all state agencies having medical consultants to appoint to each advisory panel at least one physician who is an active member of a corresponding or appropriate committee of the Illinois State Medical Society.

It is our understanding that an Advisory Committee to the Illinois Division of Vocational Rehabilitation is

being set-up with the cooperation of DVR Director Slicer, and that this committee, reporting to another council of the state society, will deal exclusively with monetary aspects of rehabilitation leaving Dr. Betts' Rehabilitation Committee with medical considerations only. Dr. Betts has taken steps to build a strong relationship with the medical consultants to DVR, but it may be necessary to consider official action to provide more adequate liaison.

In the case of Radiation, there is only one physician on the Public Health Department's Radiation Protection Advisory Committee and this individual has no strong ties with the state medical society. It may be that there is no real need for ISMS to maintain a committee on radiation if the Council had a representative such as Dr. Howard Burkhead, the current Radiation Committee chairman, as a member of the state's radiation advisory group. It is suggested that consideration be given to the current relationship that all ISMS committees have with state agencies. Communication problems may result from the fact that physician representatives on state boards, commissions, and advisory groups may lack strong ties with the medical society for one reason or another.

Joseph H. Skom, *Chairman*

Henry B. Betts

Howard C. Burkhead

Paul A. Dailey

Abraham Gelperin

Robert R. Hartman

Ralph H. Kunstadter

Edward A. Piszczek

John V. Standard

COMMITTEE ON ALCOHOLISM

In 1967, the House of Delegates of the American Medical Association approved a resolution which "identifies alcoholism as a complex disease and as such recognizes that the medical components are medicine's responsibility. Such recognition is not intended to relieve the alcoholic of moral and legal responsibility, as provided by law, for any acts committed when inebriated; nor does this recognition preclude civil arrest or imprisonment, as provided by law, for antisocial acts committed when inebriated."

The Committee on Alcoholism unanimously endorses this position and **recommends** that the Illinois State Medical Society adopt the following statement leading to implementation of AMA policy in Illinois:

Since alcoholism has for some time been widely regarded as a disease and because it is impossible for anyone to differentiate immediately between a chronic alcoholic and any other intoxicated person, the individual who is acutely ill from alcohol ingestion should be considered a health problem and therefore be adjudicated within the purview of the medical and other health professions.

To prevent the embarrassment of having the law and public opinion force the medical profession and the hospitals of Illinois to acknowledge their responsibilities in the management of alcoholism, representatives of the Illinois Hospital Association have begun meeting regularly with the ISMS Committee on Alcoholism to discuss the general problem and plan for implementation of this acknowledgment.

Clarification of the medical-legal facets of situations in other states where alcoholics are now given medical treatment instead of jail sentences is now being sought by the committee. Discussions in this regard have been initiated with legal counsel of the Illinois Hospital

Association and the Chicago Police Department and will be broadened to include other agencies and professions as deemed propitious.

The decision of the U.S. Supreme Court last summer that chronic alcoholics may be jailed for public intoxication was a disappointment to the committee and to many other interested physicians. It has been pointed out, however, that the five-to-four decision may have been based on the fact that "facilities for the attempted treatment of indigent alcoholics are woefully lacking throughout the country." The AMA thereupon has called for physicians to take the lead in programs to provide such facilities.

As the two groups most intimately involved with the management of alcoholism, the ISMS Committee on Alcoholism and representatives of the Illinois Hospital Association hope to continue the liaison initiated during the past year when two members of the committee participated in a workshop on alcoholism during the IHA annual meeting October 31, 1968, in Peoria.

It is the sense of the committee that there is a dire need for both physicians and hospitals to plan together programs of services for the proper detoxification of any individual acutely ill from excess ingestion of alcoholic spirits. It is suggested that such programs may entail regionalization of services and/or acknowledgment by all concerned that it is the duty of the physician and the hospital to provide a detoxification unit in any health facility licensed for in-patient medical and/or psychiatric care.

The committee unanimously declared that during the coming year it will seek the cooperation of the IHA and other agencies involved with acute and chronic alcoholics to formulate and submit through appropriate channels a statute that is medically and legally proper for Illinois to protect the patient, the hospital and personnel therein, police, and physicians attempting to provide humane medical attention to this widespread problem.

In addition to working for reform in the medical-legal area, the committee acknowledges its responsibility for the education of the physicians of Illinois in the care and treatment of patients in all stages of alcoholism, and it intends to conduct a seminar on the subject during the annual meeting of the Illinois State Medical Society and on such other occasions as may be appropriate.

Abraham Gelperin, *Chairman*

Charles L. Anderson	David J. Stinson
Richard S. Cook	John C. Troxel
William H. Wehrmacher	

CANCER CONTROL COMMITTEE

No report.

John V. Standard, *Chairman*

Robert E. Field	Rudolph G. Mrazek
Russell M. Jensen	Thomas Sellet
Roland A. Kowal	Caesar Sweitzer

Consultants

J. Ernest Breed	Caesar Portes
Mrs. Richard E. Icenogle, <i>Auxiliary Representative</i>	

COMMITTEE ON CHILD HEALTH

The Committee on Child Health has taken a position on several issues during the past year.

1. By a mail vote, with 11 members responding unanimously, the committee approved a draft of legislation

for hearing screening prepared by the Legislative Committee of the Illinois Commission on Children. The proposed act would authorize the Illinois Department of Public Health to establish and administer, in conjunction with the Office of the Superintendent of Public Instruction, a program of hearing screening services for the benefit of the children of Illinois, to prescribe powers and duties with respect thereto, and to make an appropriation therefor. The committee, supported by the Council on Scientific Services, agreed that there is a strong need for such a service.

2. The committee received information about a pilot program in Stickney Township where dentists are taking "throat cultures from children to detect rheumatic fever." Endorsement of the program was approved pending a favorable opinion from the Chicago Heart Association. Such was subsequently obtained via a letter from the Chairman of the Rheumatic Fever Committee of the Chicago Heart Association who wrote that the program "has been a very important liaison between medicine and dentistry in working on a mutual problem, the problem being the control of streptococcal infection and rheumatic fever. It is our feeling that this is one way that the dentist can be aware of the problem which he faces day to day, because it was found in this study that the dentist will be presented with children with mild sore throats or with upper respiratory infections. A throat culture done by the dentists and then the dentist notifying the physician of the child about a positive throat culture is another way of detecting and preventing serious disease.

"While it is true that there are other areas in which doctors and dentists could cooperate in detection of other diseases, I feel and the members of our committee feel that this is one way to begin the approach of the control of the disease through the use and consultation of allied medical personnel."

This information was forwarded through the Council on Scientific Services to the Board of Trustees for approval.

3. The Committee has spent a good deal of time studying the school health examination forms proposed by the Illinois Department of Public Health. In October, the committee recommended that the Board of Trustees approve the form with a few minor additions and alterations. One member of the committee notified the Board that he strongly objected to the form and it was referred back to the committee for further study.

The committee again reviewed the proposed form and by a mail vote (with one dissent) agreed to accept the form with the following recommendations:

- a. Space to record blood pressure.
- b. Type of tuberculin test and date.
- c. Only the dates of most recent immunization.
- d. Coded findings.
- e. Assessment of learning readiness.

These recommendations were forwarded to the Board of Trustees and considered at its January meeting, at which time Dr. Mary Zeldes, Consultant in Pediatrics of the State Health Department, appeared before the Board to discuss the form.

The Board approved the form with the understanding that the following changes (subsequently outlined in Dr. Zeldes' letter of January 13, 1969):

- A. Space will be provided for the signature of the parent or guardian of the child to be examined.
- B. Under the heading, "Significant Developmental History," will be the statement "at the discretion of the examining physician."

C. Under the heading, "Immunization Record," the type of Tuberculin Test will be requested. After "Chest X-Rays" the phrase, "if Tuberculin Test is positive" will be added.

D. Under the actual "Physical Examination," abdomen will be added to the list of body systems to be examined.

4. The committee has received information from the Illinois Department of Public Health regarding a proposed expansion of Premature Centers to include problem or "high risk" term infants. While the committee has not had time to take official action regarding this proposal, there appears to be general agreement in support of the proposal.

In accordance with previous action of the committee, letters were sent out last summer to all public high school districts and private schools in the state urging that a physician be present or *available* for all bodily contact sports and games. It was subsequently reported that ISMS headquarters received a number of responses to the letter—some indicating that schools had good arrangements with team physicians and others indicating that in certain areas the shortage of physicians was so acute that physicians were not readily available. It was also reported that the Chicago Medical Society was not in a position to supply names of physicians who might be available for high school games. It was suggested that in Chicago most injured players could be taken to a hospital emergency room about as quickly as an "available" physician could be summoned, so that this aspect of the problem was not so acute as obtaining physician's approval for an injured player to resume play.

The Committee therefore recommends that:

The Illinois State Medical Society states there is a need for a physician to be present or available to treat injuries sustained in bodily contact

sports and games conducted by Illinois public and private schools. The Society and its Child Health Committee recognize that the acute shortage of physicians in some areas makes this arrangement impossible, but county medical societies are urged to cooperate with schools in their areas to work out the best possible arrangement. It is also recognized that in Chicago and other metropolitan areas, injured players can be taken to a hospital emergency room more quickly than an "available" physician can be summoned. It is important in all cases, however, to obtain a physician's approval for a player to resume play following a potentially serious injury.

Finally, the committee took strong exception to the action of the 1968 House of Delegates which approved a recommendation that mandatory tuberculosis testing become a part of the Illinois school code referring to pre-school examination. The committee agreed that mandatory TB testing could lead to "no end of legislating what the physician must do and thus interfere with this personal freedom as a licensed physician." It did, however, request that a tuberculin test be included in the new school health form (3b).

Ralph H. Kunstadter, *Chairman*

Irving Abrams	Harvey Kravitz
Wm. J. Ball	Edward F. Lis
Marvin E. Cooper	Fred Long
Eugene F. Diamond	J. Keller Mack
Richard E. Dukes	Franklin A. Munsey
W. W. Fullerton	Kenneth S. Nolan
Edmond R. Hess	T. A. Palus
Howard R. Hone	Ira M. Rosenthal
Eduard Jung	Norman T. Welford

MATERNAL WELFARE COMMITTEE

The work of the Maternal Welfare Committee has been handicapped severely by the inability of the Illinois Department of Public Health to secure a consultant in the field of obstetrics and gynecology to replace the late Dr. John Rendok. As a consequence, there apparently has been some delay in reporting maternal deaths. The work of preparing abstracts has fallen on the hands of the members of the committee. Your committee chairman would propose to the House that great credit is due to these busy practitioners who have been willing to take time to make two or three visits outside of their home city to prepare these reports for committee consideration. A further problem brought about by Dr. Rendok's demise has been the complete halt in plans to prepare maternal death study abstracts for publication in the *Illinois Medical Journal*. At the time of the preparation of this report (15-February-69) fewer than 25 death studies have been analyzed, and it is too soon to submit any figures as to trends. However, your committee continues to feel a sense of alarm relative to the increasing prevalence of infection as a cause of maternal morbidity and mortality.

The subject of abortion continues to occupy a portion of the committee's time and the committee has reaffirmed its view that the suggestions of the American Law Institute be used as a guide for modification and modernization of the Illinois penal code. Your chairman

met with the chairman of the Religion and Medicine Committee in an attempt to coordinate the opinions of the two groups. As a result of this meeting held January 17, 1969, recommendations were made to the Board of Trustees which, summarized briefly, were: 1) there is no unanimity of opinion between the two committees; 2) an overwhelming percentage of the doctors replying to the statewide pole favored modification of the current law; 3) concern was expressed lest the state legislature take action on this matter prior to the time the views of organized medicine were crystalized. Your chairman also participated with other members of the Society in the Ad Hoc Committee to consider perinatal mortality.

In summary, the chairman wishes to thank the committee members for their cooperation and interest along with the consultants upon whom we have need to call. We would urge that every effort be made on the part of the Department of Public Health to secure a full time obstetric consultant to the end that more complete analyses of maternal deaths can be made.

Robert R. Hartman, *Chairman*

V. B. Adams	William R. Larsen
Hubert L. Allen	Harry L. Lewis
Donald M. Barringer	Hubert Magill
William W. Curtis	John C. Mason, Jr.
Frederick H. Falls	John J. McLaughlin
Hugh C. Falls	Paul A. Raber
William J. Farley	Berry V. Rife
Donald M. Gallagher	Donald R. Risley
Ralph L. Gibson	James B. Stotlar
Melvin Goodman	Charles H. P. Westfall
Charles F. Kramer	

Consultants:

Franklin D. Yoder	Wm. R. Roach
John Louis	Williard C. Scrivner
Donaldson F. Rawlings	Augusta Webster

MENTAL HEALTH COMMITTEE

No report.
 Milton C. Bauman
 E. Eliot Benezra
 Robert S. Daniels
 Irving Frank
 Mrs. Thomas Tourlentes, *Auxiliary Representative*

COMMITTEE ON NARCOTICS & HAZARDOUS SUBSTANCES

The major efforts of the Narcotics Committee during the past year have been follow-up activities connected with the National Symposium on Marijuana and Psychodelic Drugs conducted under the committee's auspices a year ago.

The committee has endorsed a bill reducing penalties for first offenses in marijuana possession and forwarded this recommendation to the ISMS Legislative Council. The chairman testified before the House Judiciary Committee in behalf of the bill and as this report is written, the bill has passed the Illinois House of Representatives.

If the bill succeeds in becoming law, the ISMS Committee on Narcotics and Hazardous Substances will be proud to have played a part in promoting wider understanding of the marijuana problem.

In supporting this bill, which was also endorsed by the State Narcotics Advisory Council, the committee em-

phasized that it in no way condones the use of marijuana and its support is intended to aid enforcement of laws now being subverted.

Joseph H. Skom, <i>Chairman</i>
Richard B. Eisenstein Jerome H. Jaffee
H. Frank Holman Kermit T. Mehlinger
David Slight

NUTRITION COMMITTEE

During the past year, the Committee on Nutrition co-sponsored two conferences and participated in discussions with representatives of the Illinois Department of Public Aid regarding dietary allowances.

On Oct. 4, the committee joined with the Illinois Nutrition Committee and the Illinois Department of Public Health in sponsoring the 11th Annual Conference on Nutrition in Medicine. This statewide conference was held in Moline and was attended by 144 dieticians, nutritionists and others plus about 100 student nurses from local hospitals. These conferences are considered highly successful by the other co-sponsors and a request has been received to conduct a similar program Oct. 3, 1969, in Charleston, and in some other location in 1970.

On Feb. 12, 1969, the committee joined with the Chicago Nutrition Association and the Chicago Section of the Institute of Food Technologists in sponsoring a Symposium on Nutrition and Food Technology. This conference was the third of its kind, although it has not been held every year. It is of national interest and this year attracted 282 persons, mostly nutritionists and representatives from food processing companies.

In accordance with instructions from the House of Delegates, the committee has met with representatives of the Department of Public Aid, the Chicago Board of Health and others to discuss education of aid recipients in the use of funds for food adequate for a balanced diet.

It was the consensus of the group that education, maintaining a "total" family, and better environment are the three basic concerns.

The Committee hopes that the greater awareness of the Congress and the Nixon administration to the nutritional needs of people on relief rolls and certain deprived groups will ease the problems of malnutrition or marginal nutrition among Americans.

Further, it is the hope of the Committee that Illinois physicians continue efforts to educate families with respect to food purchases for maximum nutrition and to encourage the wise use of food stamps.

The Chairman has great praise for Mr. Richard Ott, Mr. Perry Smithers, Miss Betty Lynch and the other personnel of the I.S.M.S. office for the help given in making these conferences so successful for the past eleven years.

Paul A. Dailey, <i>Chairman</i>
Allan A. Filek James Litsey
Richard Icenogle Harvey D. Scott
Eugene P. Johnson

COMMITTEE ON PUBLIC HEALTH

The Committee on Public Health has met twice since the last meeting of the House of Delegates and has taken the following actions:

I. Endorsed the Illinois Department of Public Health training programs to provide instruction in audiometry and hearing conservation.

2. Endorsed the Heart-in-Industry project of the Chicago Heart Association.

3. Revised and reprinted its "Manual on Safety Precautions for Laser Systems," and is making plans for still another printing to meet additional requests for copies.

4. Endorsed the combined efforts of the American Medical Association, American Cancer Society and American Heart Association regarding smoking and health.

5. Agreed to cooperate with the AMA in presenting its Congress on Occupational Health in 1972 in Chicago.

The committee took a strong position against a proposal to create a state department of Environmental Pollution Control. It is *recommended* that the Illinois State Medical Society adopt the following position statement:

The Public Health Committee has read the report of the Illinois Air Pollution Board which recommends creation of a department of environmental pollution control, headed by a director and under whom there should be a superintendent of air pollution control division. The committee believes that pollution is a health problem and that adequate controls can be set up within the Illinois Department of Public Health instead of creating a new board.

The Committee also recommends that treatment of tuberculosis be maintained as free care and it has adopted the following arguments against using "ability to pay" for tuberculosis care:

Arguments Against Using "Ability To Pay" For Tuberculosis Care

1. Tuberculosis is a communicable disease and therefore a direct public health responsibility.

2. Tuberculosis and the venereal diseases are a prime responsibility in public health programs because *TREATMENT is always necessary for CONTROL.*

Public health's primary responsibility is to provide *free treatment—regardless of ability to pay.* This is absolutely necessary in order to obtain the necessary control.

3. In the State of Illinois tuberculosis sanatoria and out-patient clinic treatment services are being provided, free of charge, by people at the local, county, district, or city level. The approval for this free tuberculosis service was provided by the local voters at the polls. The majority of the cost of tuberculosis control in the State is assumed by local tuberculosis taxing bodies.

4. Although the State of Illinois operates two State tuberculosis hospital-sanatoria, the patients treated in these institutions are charged the per diem rate which is paid by the sanatorium Board at their place of residence. Charges are collected and sent into the general revenue fund. The State assumes some financial responsibility for "non-residents" because of the contagious nature of the disease which comes under the broad clause of "public health protection."

State tuberculosis hospitals also render chest services to other departments of the government (example: Department of Mental Health and Public Safety) without charging for such services.

5. With the introduction of Medicare payments to people over age 65, tuberculosis sanatoria in the State began collecting any Medicare benefits obtainable from eligible patients. Since Medicare benefits are limited to a specific period of time, the Medicare program does not usually cover the entire cost of hospitalization. The

average stay in the tuberculosis hospital today, regardless of age, is approximately four to five months. Medicare benefits pay for only 90 days. Yet, collection reduces the local tax load.

6. The problem of tuberculosis today at the various age levels is illustrated in the breakdown of the 384 suburban Cook County residents admitted to the hospital-sanitarium at Hinsdale. This breakdown includes:

Age Group	Number	Percent
Total	384	100.0
Children under 15	17	4.4
15 - 24	18	4.7
25 - 34	30	7.8
35 - 44	75	19.5
45 - 54	75	19.5
55 - 64	70	18.3
65 - over	99	25.8

In this breakdown, 25.8% of the cases are over the age of 65 and eligible for Medicare benefits.

In fact, in the United States today, about two-thirds of the active cases of tuberculosis fall in the over-45 age group.

For the year 1966, 85% of the deaths attributed to tuberculosis in the United States involved people over the age of 45.

7. The importance of tuberculosis out-patient clinics is well known. Although patients may stay in a tuberculosis sanatorium for a period of three, four, or five months, they may continue to take drugs for a period of years, or even during their entire lifetime, after the attack of tuberculosis.

Out-patient clinics are essential in the treatment of this disease to *control* the spread of the disease and to *treat* the disease effectively. When a case of active tuberculosis is found in the family, all family and direct contacts with that active case of tuberculosis require tuberculin testing, X-rays, possible isoniazid chemoprophylaxis, and periodic observation to make sure they have not been infected. These are public health measures enacted to protect the public. These measures would become failures if the public had to pay for this service plan. Also, old inactive cases of tuberculosis would not feel obligated to pay to protect the public.

8. One of the essentials of a good tuberculosis control program is case finding. This may be done by tuberculin testing programs of pre-school children, by periodic surveys in grade schools, high schools, and colleges, as well as by mass X-ray surveys in communities, in industries, in nursing homes, etc. State and/or local law now requires that school personnel, teachers, barbers, beauticians, food handlers, and all persons entering and living in a nursing home must have an *annual certificate* proving *freedom* from contagious tuberculosis. These testing programs have been carried out by tuberculosis and public health agencies. They have been productive and work effectively in the State of Illinois. All of these tuberculosis detection programs protect the public. Its value cannot be measured in dollars and cents.

9. The large American cities and the metropolitan areas around these cities continue to produce the highest incidence of tuberculosis in the United States. A great deal of tuberculosis is found among minority groups of the population and is associated with problems of housing, general nutrition, and other socio-economic factors. Chronic alcoholics also present a major tuberculosis problem.

Where the incidence of tuberculosis is still high among the unrestricted migration of population groups, such as Mexican, Puerto Rican, and Cuban, prevention of the spread of tuberculosis to the public requires periodic X-rays and medical followup of these immigrants. These people, who are permitted by our government to enter this country, must inform public health officials of their residence. To expect these immigrants to pay would be an open invitation to them not to cooperate.

It is often exceedingly difficult, even now, to get this group to accept free care for the patients and the contacts. The introduction of another "ability to pay" barrier in their lives would only increase this already existing problem.

10. The introduction of "ability to pay" in the tuberculosis control program is contrary to the first principles of public health law. The free treatment of tuberculosis and the venereal diseases, where treatment is necessary for control, is not comparable to the "ability to pay" philosophy, which was introduced in mental health programs, county hospital programs, nursing home programs, old peoples' homes, etc. These do not deal with contagious disease principles but with a primary basis of medical or custodial care. The marked advances in the control of tuberculosis have mainly been achieved by the advances in medical research and the availability of free tuberculosis care. These factors are responsible for tuberculosis being the last of the major contagious diseases in public health today.

The same free care, out-patient programs, and case-finding programs that are available today should be continued for at least another generation until those people, who were infected early in life because of the use of unpasteurized milk and the high incidence of disease in the family or the community, have passed on.

With increased longevity, people are living longer only to contact diabetes, arteriosclerosis, influenza, pneumonia, arthritis, other chronic debilitating digestive and respiratory diseases and then break down with tuberculosis. At this time it would be "penny wise and pound foolish" to discontinue a program for free services in tuberculosis which shows the promise, not only of control, but of eventual eradication of the disease in the United States.

E. A. Piszczek, *Chairman*

Kenneth G. Bulley	David F. Loewen
Clifton Hall	Robert J. Maganini
Edward C. Holmblad	Karl H. Pfeutze
John S. Hyde	Arthur E. Sulek
George H. Irwin	

Warren W. Young, *Consultant*

RADIATION COMMITTEE

According to the responsibilities and purposes assigned to the Radiation Committee, the committee shall serve as a source of information on radiation matters for ISMS and evaluate available information and make recommendations to the Board for the position ISMS should take on issues in this area. It shall cooperate with institutions and voluntary health agencies in disseminating information on radiation subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correcting for the protection of the public.

To fulfill these purposes, the committee is required to maintain close liaison with the Radiation Protection Advisory Council of the Department of Public Health, the state legislature, and communications media.

Although there has been an improvement in dissemination of information from the Department of Public

Health, this information often does not reach the committee in time to call a meeting, consider the issue and report to the Board of Trustees before legislation is enacted.

It is therefore recommended:

That the Illinois State Medical Society request the Illinois Department of Public Health to appoint to its various advisory committees such ISMS committee chairmen or delegates as will be appropriate for maintaining adequate communication between the department and the medical society in matters affecting physicians of Illinois and the practice of medicine.

Such dual committee assignments would insure that the Illinois Department of Public Health would have direct access to physicians currently active in affairs of the Illinois State Medical Society, thus enhancing the opportunity to provide the leadership of the society with up-to-date information while there is ample time for action.

The Council on Scientific Services was presented with the above recommendation with the thought that all state agencies having medical advisory councils might be requested to make appointments in cooperation with the Illinois State Medical Society in an effort to help organized medicine act before the fact rather than afterwards.

Howard C. Burkhead, *Chairman*

Abraham H. Cannon

Stephen L. Casper

J. Homer Goodlad

Stuart P. Lippert

Howard C. Neucks

James J. Nickson

Hyman R. Osheroff

Norman R. Shippey

Raymond B. White

J. Ernest Breed, *Consultant*

COMMITTEE ON REHABILITATION SERVICES

The Committee fulfilling the purposes established by the Board of Trustees ("provide a liaison between the Illinois State Medical Society and the Division of Vocational Rehabilitation and the Department of Public Aid and other official or non-official agencies") met in June and September, 1968, to initiate and sustain effective liaison with the rehabilitation agencies.

At the outset, the Committee strived to promote and maintain a more effective communications relationship between members of the professional medical society and the medical consultants and program directors of the Illinois Department of Vocational Rehabilitation. The Chairman of the Committee spoke to the medical consultants of DVR at their annual meeting covering the lack of information, mis-information and limited communications between physicians active in rehabilitation and the professional medical community. As a result, the medical consultants and the DVR will initiate programs to inform physicians through their professional societies of the problems and activities of governmental and private rehabilitation efforts.

Evidently, as a result of this condition, the medical society has created and appointed an advisory committee to the Illinois Division of Vocational Rehabilitation. This Committee will absorb the liaison function previously delegated to the Committee on Rehabilitation Services. The Committee shall continue to develop working relationships with other governmental and private agencies in the field of rehabilitation and offer assistance in the establishment of policies regarding rehabilitation

facilities, selection of patients, training of rehabilitation personnel and in the promulgation of high quality care.

The Committee wishes to acknowledge the participation of the Committee members and consultants and the guidance and direction of the Board of Trustees.

Henry B. Betts, *Chairman*

Eli L. Borkon

Joseph L. Koczur

Bruce C. Ehmke

John G. Meyer

John E. Finch

Arthur A. Rodriguez

Frank B. Kelly, Jr.

Frank J. Jirka, Jr., *Consultant*

ILLINOIS DEPARTMENT OF MENTAL HEALTH

Mental illness and the symptomatology of mental illness is in actuality a series of illnesses—ranging from specific and traditional psychiatric disorder categories to varying other psycho-social dysfunctions which affect patients and their families.

These are revealed as social incompetence, familial and community disruption, inability to manage financially, etc. Usually these factors cannot be isolated and labeled "psychiatric disorder." Treatment must deal with the total individual and with the social, economic, vocational and educational forces within the community.

The Illinois Department of Mental Health is striving to develop a broadly-based network of comprehensive community mental health services, designed to be readily accessible to the total population of a defined area. Ultimately, the objective seeks methods for intervening with effective treatment at the onset of disorder, at the time—and in the environment—where the disorder occurs. Treatment is most beneficial when it is developed with as little interruption to the patient's daily routine as is possible.

Community mental health programs are based on (1) successfully dealing with the individual in stress with access to his family and other community resources; (2) maximizing those resources for total intervention; (3) development of discreet linkage with public and private welfare agencies, medical-surgical facilities and vocational agencies; (4) consultation and education so that the community will recognize that a patient can live in their midst without danger to his neighbors, his family or himself.

Prior to 1960, the mental health system as it functioned in Illinois and throughout the country had serious deficiencies. It removed people from their homes and communities and placed them in isolated hospitals for excessive lengths of time. Prolonged hospitalization often is not necessary—even for treating the most acute psychiatric disorders—if rehabilitation services, social work, and other supporting agents are available in the community.

Prolonged hospitalization may damage a person's ability to function as a productive citizen. A person is at the least operative level while he is hospitalized; he often finds refuge in this retreat from reality and becomes dependent upon his hospital environment.

The Department of Mental Health, with limited resources, seeks to provide "back-up" programs for the emerging community services. These include, but are not limited to, inpatient treatment for patients requiring removal from their immediate environment; extensive inpatient care for the small percentage of patients unable to function at any level in the community; intensive outpatient therapy for patients who can function in the community with reinforcement; specialized services for particular problems such as narcotics addiction, alcoholism, mental retardation, multiple-handicapped,

etc.; and education and consultation for developing an existing community program.

Successful return of patients to productive living is accomplished through a series of steps beginning with a careful and adequate screening of the patient and his problems; as well as an assessment of his resources—his familial and community supports.

Treatment may then take the form of drug therapy, group therapy, day-care, vocational rehabilitation, individual psychotherapy or a combination of these. Family participation and support is especially essential, as is consultation with employers and other care-givers—the schools, nursing homes, physicians, and police.

Such a carefully based community program builds in a highly structured referral system. It also defines the role the various support elements will provide; and it helps stabilize the social setting for patients, potential patients, and "healthy" citizens to live harmoniously. Mental hospitals, zone centers, and the state schools for the mentally retarded then are able to more successfully treat the "high risk" group—those patients at an acute stage of illness where hospitalization is either imminent or mandatory.

For a significant number of these patients, short-term hospitalization with aftercare linked to the community is a most effective way to bring about a return to productivity. In these instances, a brief respite from immediate environmental pressures will assist in helping the patient to reach an ability to respond to treatment.

A small, but significant, percentage must be considered permanently disabled as far as an ability to contribute economically to society. These are, largely, our elderly—our geriatric patients. Many of these people can live in community settings if they receive support to maximize the potential they retain. This can be accomplished with careful screening to be certain they are able to live in the community harmoniously. Elderly patients, as any other persons, seek to live in as normal a setting as is possible. It is the mark of a mature society to not only provide for the return of totally productive citizens, but to accept and provide for residence of disabled citizens in the community. They, too, can live in dignity and respect and participate in community activities up to their maximal potential.

Outpatient programs have a specific role in the transition between inpatient care and recovery. Patients may return to the hospital because supporting services in the community either break down or are non-existent. Post-hospitalized people attempting to adjust to community living are not always able to find employment, places to live, manage their own medication, and achieve satisfying social activities. If these supports are not available to them, they frequently withdraw into illness again—their refuge is the hospital. As this happens, previous success in treating their illness is submerged or minimized.

To effect the necessary network of services requires a careful blending of public and private resources at all levels—local, state and federal. The Department of Mental Health is seeking to expand this network, so that more effective methods for delivering services to people in need may be achieved.

Communities may call upon the state, through the Department, to help them through grants-in-aid, consultant contractual agreements, and for assistance in planning.

Department facilities—zone centers, hospitals, and schools—are increasing outpatient services as well as seeking to improve the quality of inpatient care. Outpatient

programs measurably assist patients to move from one service to another with less risk of "falling between the cracks." These Department outpatient programs are provided in conjunction with resources of the local community.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

The following is an abbreviated report of the programs and activities of the Illinois Department of Public Health. A more complete detailed report of the Department's programs and activities will be made available in the handout packet issued to each delegate to the 1969 Illinois State Medical Society House of Delegates.

Dental Health

The mandatory fluoridation act passed in July, 1967, stipulates that all public water supplies in Illinois, regardless of size, must be fluoridated. To date over three-fourths of the public water supplies in the state, representing a population of almost seven million persons, have either accomplished fluoridation or are in the process of so doing.

To augment the reduction of dental disease, a comprehensive prevention program has been instituted whereby community leaders are assisted in conducting topical fluoride programs for school children.

The division has ordered a modern mobile dental clinic to provide limited care to the most needy migrants and dentally indigent. The division has also inaugurated a residency program whereby graduate public health dentists serve one year to complete partial requirements for the specialty board in dental public health.

Electronic Data Processing

The Bureau of Electronic Data Processing functions as a service agency to all divisions and bureaus of the department by providing statistical reports on health information important to planning, organizing, directing, controlling and coordinating program activities.

In June, 1968, steps were taken toward the creation of a long-range Total Health Information System. THIS is aimed at developing a more effective characterization of multifaceted health problem areas and an improved allocation of both private and public resources to service existing needs.

The development of THIS is structured in the following planned sequence:

Phase I—Development of Integrated THIS Concept

Phase II—Systems Design

Phase III—Programming and Implementation

Phase I was completed in March, 1969. Phase II, underway, is scheduled for completion in mid-1970. The eventual establishment of a single computer-based health information system will permit integration of demographic, public and private health resource, status and need data, including air and water pollution data. The THIS data bank will be available to the system's users as a management tool to effect a "partnership for health" approach in effective comprehensive health planning.

Food and Drugs

The federal-state partnership for health plan has played a significant role in division activities this year. The Chicago District Food and Drug Administration has been instrumental in training two drug inspectors and one pharmaceutical chemist who are the nucleus of the state drug control team.

For the first time a working agreement is in effect with the Chicago District Food and Drug Administration whereby the inspectional workload in the state is programmed between the two agencies to prevent duplication, provide for a free exchange of inspectional data and laboratory results and provide a more complete coverage of processing plants.

Health Care Facilities and Chronic Illness

The division administers the heart, rheumatic fever, cancer, glaucoma and diabetes programs, and provides consultation in the field of nutrition for the division and the department.

The division established a Chronic Renal Disease Program to provide help to Illinois residents who suffer serious chronic renal failure. One million dollars was appropriated by the 75th General Assembly to implement the program over a two-year period.

The division also administers the state licensing program for hospitals, independent laboratories and long-term care facilities as well as the Medicare certification program for hospitals, extended care facilities, independent laboratories and home health agencies; plans, directs and implements the Rehabilitation Education Service program throughout the state; administers the Hill-Burton program and the Packaged Disaster Hospital program; provides professional expertise to the department in medical specialties and other scientific fields; and is responsible for compiling vital data for the preparation of cost studies, maternity activities and gynecological studies.

Health Education

Health education is the process whereby people alter or change their health habits and behavior. The bureau has the mission of providing public health workers at state and local levels with those educational and informational services best calculated to facilitate the understanding, acceptance and use among the population of the most up-to-date scientific information about health. The bureau has the responsibility to disseminate accurate information about health and health conditions in the state.

Health Planning and Resource Development

The activities of the division continue to be directed toward the formulation of plans, policies and procedures for the implementation of P.L. 89-749 and its amendments contained in P.L. 90-174. Local communities are encouraged to organize for planning aimed at solving particular local health problems. The division's functions include the gathering of information regarding programs and activities of all of the voluntary and official, public and private, medical, dental, nursing and other health related personnel, resources and facilities; collating, recording and studying them; and making recommendations to establish priorities among existing activities, encouraging new activities if needed and eliminating unnecessary duplication.

Laboratories

The division's activities are carried out by the bureaus of Diagnostic Services, Sanitary Bacteriology, Evaluation, Biologic Products, Virus Diseases and Research and Toxicology. The results of chemical, bacteriological and radiological examinations provide a continuing evaluation of the sanitary quality and safety of water, milk and other dairy products and the efficacy of sewage treatment plants.

The division is also responsible for approving local independent laboratories, providing toxicological services to coroners and law enforcement agencies, the production and testing of biologic products and specialized reference and consultation to other laboratories.

Local Health Services

The major responsibility of the division concerns the functioning of 46 autonomous county and multiple-county health departments and ten city and local district health departments, and the department's six regional offices. The division serves in a liaison capacity for the department's program directors, the regional offices and the local health departments, assisting in their implementation of Illinois Public Health Laws and Rules and Regulations by providing channels of communication and through counseling. The division also administers the grant-in-aid program to local health departments, and helps in the allocation of other state and federal funds to health departments.

The division has the responsibility for developing, in collaboration with other department offices, and administering standards related to programs and performance, as well as minimum qualifications for personnel, in local health departments.

Milk Control

Safeguarding the health of Illinois milk consumers continues to be a responsibility of the department. The administration of dairy laws and regulations is gradually transferring from municipal to state level. The department is presently cooperating with a legislative commission which is conducting a study of laws regulating dairy products. Legislation is planned to update and repeal outdated statutes.

Nursing

The bureau gives consultative and advisory service to all public health nurses in the state including those employed by the department, those employed in schools and industries, and those employed in city, county and regional health departments and private agencies. The bureau is also responsible for recruitment, training and placement of nurses; for continuous staff education; for developing sound professional standards; and for promoting leadership in the profession.

Preventive Medicine

The division administers a program for the care of premature infants; the PKU screening program; a program of limited health services for migrants; three major services in the areas of hearing conservation including audiometric screening, otologic-diagnostic clinics and training; a vision screening program with increased emphasis on finding Amblyopia Ex Anopsia through mass screening programs; programs for prevention and control of communicable diseases; and an expanded venereal disease control program.

The first compulsory immunization law in Illinois enacted in July, 1967, charged the department with the responsibility for promulgating rules and regulations for immunization. Such rules and regulations have been issued.

The department's new section on traffic safety includes setting standards for the operators of breath analyzing devices, certification of clinicians or technicians engaged in blood alcohol testing and developing curricula for

operators of breath analyzing devices. Early in 1968 the Alcohol Blood Project was resumed as a joint responsibility between the department and coroners of the state.

The division administers the Uniform Hazardous Substances Act by requiring proper warning and ingredient statements on products, by investigation of violations of the law and by taking proper steps to correct violations. It establishes and directs poison control centers in interested hospitals in accordance with standards developed by the American Association of Poison Control Centers—96 such centers are operating now in Illinois.

Sanitary Engineering

Surface water quality standards were revised to meet requests of the U. S. Department of Interior. Due to variations in quantity and usage of streams, eight separate standards were developed. Major effort has been and will continue to be directed toward sewage treatment works expansion, improvement and efficient operation in order to upgrade stream water quality or maintain present high quality waters.

The radiological health program has the overall objective of assuring that sources of ionizing radiation are used safely. In accordance with the provisions of the Radiation Monitoring Act, and the regulations which have been developed, the department is maintaining records on occupational external radiation exposure for employees receiving exposure to ionizing radiation in Illinois. The Act also provides the department with the authority to approve film badge monitoring services.

The state owns 20.4 acres of land in Bureau County which is being used for burial of radioactive wastes in accordance with the Radioactive Wastes Act. The site is operated by a private firm with the department having supervisory responsibility.

The department administers the Laser System Registration Law which requires registration of laser systems and reporting of accidental injuries.

The department is responsible for overall state radiological defense service which includes the maintenance and calibration of all radiological monitoring instruments in the state.

Tuberculosis Control

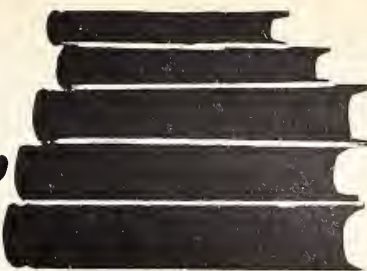
The department has continued efforts to promote hospitalization of all active cases of tuberculosis; secure the treatment of non-hospitalized cases; insure the examination of contacts and suspects; provide for tuberculin testing of school children in grades one, five and nine and school personnel; documentation and examination of household associates of reactors in grades one and the encouragement of those infected to take chemotherapy in the form of INH for one year.

Vital Statistics

Revised certificates for recording live births, fetal deaths, deaths, marriages and divorces became effective January 1, 1968. The forms were designed to meet demands for legal and statistical information and to conform more closely to the U. S. Standard Certificates recommended for nationwide use by the U. S. Department of Health, Education and Welfare's National Center for Vital Statistics.

Special handbooks were issued to accompany the certificates for hospitals on births and fetal death registration, for funeral directors on death and fetal death registration, and for physicians on Medical Certification: Death, Fetal Death and Birth.

MEDICAL EDUCATION



Council on Medical Education

The Council on Medical Education has met on numerous occasions since the 1968 Convention. It has received the reports of its component committees, submits the following comments and recommendations.

The Council concurs with the Committee on Medical Education that the Preceptorship Programs, such as the one that has been operating in DuPage County, should be expanded. It has been suggested that if the ISMS Preceptorship Program were expanded to operate in additional counties, the five medical schools in Illinois might consider a cooperative system of supervision and appointment so that unfilled openings in one school's program might be used by students from other schools. The resolution regarding state subsidies for private medical schools introduced last year and passed by the House of Delegates has been subsequently referred to the Council on Legislation for implementation.

The Committee on Continuing Education continues to assess, evaluate and coordinate on-going and future programs for continuing education. The Scientific Speakers Bureau roster has been revised and updated and the Council urges the component county societies and hospital staffs to utilize this service whenever possible. In order to assess needs and desires of Illinois physicians for continuing education, the committee plans to ask Illinois physicians to voluntarily catalog their continuing education activities on a form provided by the State Medical Society.

Under the guidance of the Advisory Committee to the Student American Medical Association a new program involving students in community hospitals during the summer quarter will be initiated this year. The Summer-Job Education Project for Freshmen and Sophomore medical students is a real opportunity to involve the student in clinical practice and expose him to various methods of health care delivery, both inside and out-

side the metropolitan area. All hospitals and medical staffs in the state have received information regarding this program. The Council urges participation by as many community hospitals as possible.

The Board of Trustees has approved the recommendation by the Council that such steps as may be necessary be taken to provide voting representation of the Student American Medical Association on such ISMS councils and committees where it is felt the student viewpoint would be valuable to the Society and to the physicians of Illinois. Investigation of some sort of student membership that would allow such representation is underway.

The Committee on Scientific Assembly continues to work diligently to provide an interesting and comprehensive meeting for the members. The Council recognizes the difficulties of attracting both members and exhibitors and recognizes that this is a problem for other organizations as well. The Board of Trustees has agreed to a Council recommendation that they investigate the possibility of combining the annual meetings of the Illinois State Medical Society and the Chicago Medical Society. It seems to the Council that such a cooperative venture would be beneficial to all the physicians in the state.

In the opinion of the Council the Student Loan Fund is only one area of concern in the total rural health picture. The Council feels that these rural health concerns might best be served by separating the Rural Health from the Medical Student Loan Fund activity and placing it under the Council on Medical Service as a separate committee and in this recommendation the Board of Trustees has concurred.

Jack L. Gibbs, *Chairman*

Herschel L. Browns

Morgan M. Meyer

Robert T. Fox

J. Robert Thompson

Paul W. Sunderland, *Consultant*

COMMITTEE ON MEDICAL EDUCATION

The Committee on Medical Education has met three times since the last meeting of the House of Delegates.

Its July meeting was attended by representatives of the Student American Medical Association who proposed that the Illinois State Medical Society co-sponsor a summer job program for medical students. Representatives of the Illinois Hospital Association and the Illinois Academy of General Practice, which would be the other co-sponsors of the project, were also present as well as a representative of Illinois Masonic Hospital, where a pilot program of this nature was operated last summer.

Following discussion, the committee voted to present this recommendation to the Board of Trustees:

The Illinois State Medical Society shall encourage the development of orientation programs that will provide medical students with an exposure to the practice of medicine beginning with summer jobs prior to the freshman year,

more structured educational work experiences the following summer, and regular preceptorships in the third year. The programs should be developed in cooperation with the Student American Medical Association and the Illinois Hospital Association, and particular attention should be given to downstate areas. Primary responsibility for the programs should be assumed by the medical staffs of hospitals, rather than personnel offices. Promotional materials should stress the goals of the program to acquaint students with the various methods of private medical practice.

The Board subsequently appointed an ad hoc committee to investigate and pursue the project. As a result of this group's investigation, the Board agreed to co-sponsor the program this summer and appointed a permanent Advisory Committee to the Student American

Medical Association to supervise the program and provide the students with sustained guidance.

The Committee on Medical Education is proud to have had a part in what appears to be the beginning of a successful program which hopefully will be advantageous to all concerned.

The Committee continues to be interested in preceptorship programs such as the one that has been in operation in DuPage County, and it has made the following **recommendation:**

County Medical Societies and hospitals, wherever interested, in non-metropolitan areas, should be encouraged to support preceptorships financially on a local basis.

It has been suggested that if the ISMS preceptorship program were expanded to operate in additional counties, the five medical schools in Illinois might consider a cooperative system of supervision and appointment so that unfilled openings in one school's program might be used by students from other schools.

It is hoped that freshman and sophomore medical students participating in the Summer Job Project will become interested in preceptorships in their junior and senior years and thus provide the impetus for expansion.

At all of its meetings the Committee on Medical Education has discussed implementation of Resolution 68M-10, state subsidies for medical schools. This resolution was inspired by the Committee last year and passed by the 1968 House of Delegates. It was subsequently referred to the Council on Legislation which accepted the concept presented in the resolution, which calls for across-the-board subsidy of all medical schools in the state, and recommended that legal counsel prepare a suitable bill to be presented to the Board of Trustees for approval.

The committee this year welcomed two new medical school representatives to its meetings—Dr. Richard Landau of the University of Chicago, and Dr. Nicholas Cotsonas, Jr., of the University of Illinois.

Morgan M. Meyer, *Chairman*

William F. Hubble

Jerry Ingalls

Mays C. Maxwell

R. Charles Oldfield, Jr.

F. R. Riordan III

Robert J. Schafer

Medical School Representatives

LeRoy Levitt, *Chicago Medical School*

Nicholas J. Cotsonas, Jr., *University of Illinois*

Richard Landau, *University of Chicago*

Edward S. Petersen, *Northwestern University*

William Barrett Rich, *Loyola University*

Consultants

Paul W. Sunderland

Philip G. Thomsen

William E. Adams

The Chicago Medical School

I am responding to your letter relative to the disposition of the AMA-ERF funds contributed to The Chicago Medical School in 1968. In April, 1968, we received the sum of \$21,218.10. During this year these funds have been of great service as they always have been in years past. With the somewhat abrupt decrease in funds from many other public and private sources, these AMA-ERF funds become increasingly important to us in carrying forward vitally needed positions in our educational program. This year the funds were carefully apportioned again among many positions in amounts ranging from \$3-\$5,000. This is in part support of both salaries and their ever increasing amounts which every institution must maintain. The following positions are involved in this support:

(1) Assistant Professor in Obstetrics & Gynecology

(2) Assistant Professor in Psychiatry

(3) Associate in Pediatrics

(4) Assistant in Medicine

The remaining approximately \$1,200 has been utilized to partially support four student projects which involve some traveling time and brief maintenance elsewhere in the country.

The severe restrictions in our teaching budget are always eased somewhat by the opportunity to have some unrestricted funds that can be quickly allocated where they are most needed. It is my earnest hope that these funds will expand in order to provide greater improvement in the teaching opportunities to our medical students.

In behalf of our institution, I want to express our deepest appreciation for this clear evidence of cooperation and dedication.

Sincerely,

LeRoy P. Levitt, M.D., Dean

Loyola University—Stritch School of Medicine

As you know, the Loyola University Stritch School of Medicine received an award from the AMA-ERF funds in the amount of \$24,566.10 in 1968. In addition to providing our school with the opportunity of employing three part-time members of the faculty in connection with our undergraduate teaching program at the Cook County Hospital, we were able to underwrite the purchase of some scientific equipment in two of the basic science departments that enable them to perform some preliminary investigations and research. As a result of this activity, two significant grants have been awarded for the carrying out of some basic research protocols.

From the above, it is quite evident that the contribution of the membership of the Illinois State Medical Society has played a vital role in the conduct of not only our research programs in the basic science areas but also in the implementation of our clinical teaching and patient care programs in the Cook County Hospital environment. Therefore, I am confident that our expanding programs in the field of medical education would be considerably hampered were it not for the outstanding financial assistance that has been rendered to the Stritch School of Medicine over the years by the membership of the Illinois State Medical Society.

In closing, I would like to take this opportunity to extend our deep appreciation to the membership of the Illinois State Medical Society for their generous support of our efforts in the field of teaching, research and patient care.

Very truly yours,

John G. Masterson, M.D., Acting Dean

Northwestern University Medical School

The funds received from the AMA-ERF through the Illinois State Medical Society always have been used in the support of faculty salaries. We have felt that the basic need of our school, as well as any medical school, is primarily to have funds applied to the salary budget.

The salaries at Northwestern University have had a difficult time keeping up to the median of our sister schools throughout the country.

I feel very specifically that funds from the profession should not go into research projects, experimental projects, buildings or equipment. There can be no more direct support of a medical school than through the support of personnel.

We have not designated any single faculty member as a recipient of the AMA-ERF funds but have used them where necessary to hold individuals when there was a possibility of losing them through their having received more attractive financial offers than we could otherwise meet. In this day with the expanding number of medical schools the competition in the faculty marketplace is getting to the point of absurdity. One school

has no compunction about stealing from another. The AMA-ERF funds are most important in allowing us to hold things together.

Sincerely yours,
Richard H. Young, M.D., Dean

The University of Chicago Pritzker School of Medicine

I am responding to the request for a report on the disposition of AMA-ERF funds contributed by your membership toward the support of medical education. Last year's grant of \$16,147.10 was used to assist in the retention of the high quality faculty members we must have to teach medical students. We feel very keenly the ever-increasing costs of recruiting, training and providing initial research support for the most promising young teachers, only to face the loss of such people unless we have the resources needed to retain their services. Hence this very important segment of unrestricted support has enabled us to make several decisive moves this past year to save some of our best people from leaving.

In the past we have emphasized the importance of unrestricted salary support, but with the rising costs and increasing demands placed upon medical schools we simply could not exist without it. We at the University of Chicago are grateful for the assistance which has been provided each year by AMA-ERF contributions.

Sincerely,
Leon O. Jacobson, M.D., Dean

University of Illinois College of Medicine

I am glad to be able to report on the uses to which the University of Illinois College of Medicine has put the AMA-ERF funds that have been so generously contributed by members of the Illinois State Medical Society. This report covers the period of January 1, 1968, through December 31, 1968.

The funds have been used in five general areas. First, five different faculty members have received a portion of their salary from AMA-ERF funds. These individuals are working in the Department of Pathology, Surgery, or Otolaryngology. Second, a new elective program in animal surgery was supported by the AMA-ERF funds. The program has proven to be very popular and is designed to teach sterile technique. The operations performed are done so to provide models for physiological experiments. Third, four visiting lectures were brought to the campus to augment the regularly scheduled programs. Fourth, a small sum of money has been used to publish a newsletter in order to improve the communication between the Office of the Dean and the faculty. Including the volunteers, the faculty of the College of Medicine numbers about 1,500 persons. It is important that communications with these faculty members be improved. And fifth, two classroom areas in the clinical departments have been renovated to make it possible to accommodate additional students, as well as to provide modern teaching aids.

I hope this review will provide the Society with a picture of the manner in which their contributions have helped to improve the educational process at the University of Illinois College of Medicine.

Sincerely yours,
William J. Grove, M.D., Dean

COMMITTEE ON CONTINUING EDUCATION

Although the Committee on Continuing Education is striving to develop new and meaningful programs for Illinois physicians, its chief activity during the past year

has been operation of the Scientific Speakers' Bureau and planning publication of a new Roster of Speakers.

During the calendar year 1968, 19 county medical societies made use of the Bureau's services and 68 physicians addressed county society meetings through the auspices of the Bureau.

Based on the success of the program, Merck Sharp & Dohme contributed a one-time special grant of \$1,000 to revise and reprint the roster and for the seventh consecutive year contributed \$5,000 for operation of the Bureau during calendar 1969. The latter grant is used to pay expenses and honoraria for physicians speaking at county medical society meetings.

The new roster will be similar to the last one which was published in 1965, except that provision has been made to utilize speakers from adjacent states in addition to those from Illinois. This move is made in recognition of the association which many Illinois physicians have with medical schools in nearby states.

Preliminary discussions have been held with Merck Sharp & Dohme regarding the possibility of funding a Visiting Physician Program. Such a program would entail recruiting one or more physicians to go into a hospital for a period of several days to help the hospital's medical staff and other personnel set up coronary care units, inhalation therapy departments, etc. The committee will continue to explore this kind of program.

During November, several members of the Committee attended the AMA Conference on Continuing Medical Education and learned about a new AMA recognition program for physicians demonstrating efforts to "keep up" with medical progress.

In an effort to discover and hopefully provide for the continuing education needs of all physicians across the state, the chairman early in the year requested trustees to appoint representatives in districts where the committee had no members so that liaison could be established in all areas. This has been successful in some cases. However, the geography of the state continues to be a problem to this committee and it is now recommended that:

The Committee on Continuing Education be split into two separate units under one chairman in order to better service the needs of physicians downstate as well as those in the Chicago area. It is requested that all trustee districts be represented on the committee and that meetings be held regularly downstate as well as in Chicago.

Because of the increased emphasis on continuing education for physicians, it is further recommended that the Illinois State Medical Society consider that membership dues bills be accompanied biennially with a form for physicians to catalog their voluntary continuing education activities.

Based on the experiences of states where continuing education of physicians is more advanced than it is in Illinois, it is further recommended that the ISMS Committee on Continuing Education have regular representation from the five medical schools in Illinois, there being no organized effort made currently to coordinate any continuing education efforts of either medical schools or teaching hospitals.

It is recognized that the Regional Medical Program, with the recent impetus of the government's emphasis on education, at the present time is the single most important factor in new programs of continuing education. The role of the ISMS Committee on Continuing

Education under these changing circumstances will continue to be that of assessing needs and evaluating on-going and future programs, but especially to coordinate because state and regional boundaries may differ.

Herschel L. Browns, *Chairman*

W. W. Bowers	Louis N. Katz
T. Howard Clarke	Louis R. Limarzi
Robert L. Craig	Herman Nebel
Lawrence C. Day	James M. Schless
Robert J. Freeark	Gordon S. Sprague
Richard F. Herndon	

District Contact Men

W. R. Bertelsen	T. Z. Polley
E. K. Griffiths	Wm. H. Walton

W. E. Adams, *Consultant*

ADVISORY COMMITTEE TO THE STUDENT AMERICAN MEDICAL ASSOCIATION

The Advisory Committee to the Student American Medical Association was re-activated as a permanent and independent committee reporting to the Council on Medical Education.

Its first duty was to implement a summer job-program for freshman and sophomore medical students which the Illinois State Medical Society will co-sponsor this summer with the Illinois Hospital Association and the Illinois Academy of General Practice.

Patterned after a pilot program initiated last summer at Illinois Masonic Hospital in Chicago, the program is expected to involve several hundred students and dozens of hospitals this year. Purpose of the program is to provide students with an early exposure to a variety of health care systems.

During the ten-week period, the students will perform medically-oriented jobs in hospitals while following a flexible but structured routine where they are expected to gain insight into the practice of medicine not available in the university setting.

The committee is turning its attention to areas where it can provide sustained guidance to medical students in Illinois.

In order to increase opportunities for two-way communication, the committee recommends that:

The Illinois State Medical Society take such steps as may be necessary to provide representatives of the Student American Medical Association with voting membership on such ISMS Councils and Committees where student viewpoint would be valuable to the society and the physicians of Illinois. The committee recognizes that these steps may require changes in the Society's Constitution and Bylaws regarding membership in county societies, but it is the sense of the Advisory Committee to the Student American Medical Association that provisions be made for some sort of membership that will allow the voice of the students to be heard.

Norman Frank, *Chairman*

Allison L. Burdick, Jr.	Nathan Iglitzen
N. Kenneth Furlong	H. Marchmont-Robinson

Thomas R. Harwood, *Consultant*

Bruce G. Fagel, *SAMA Representative*

RURAL HEALTH AND MEDICAL STUDENT LOAN FUND COMMITTEE

On January 29 and 30, 1969, the Joint ISMS/IAA Committee met in Bloomington at the IAA offices for a business and applicant interview meeting. The business meeting discussion centered around the sound fiscal status of the fund. Since many of the present program partici-

pants have not requested the loan portion of the program, more extensive use of accumulated funds to accomplish the purposes of the program is indicated.

It was agreed by the Loan Fund Board that the goal of providing more doctors in rural areas can be served by more extensive promotion of the benefits and medical sophistication increasingly evident in non-urban areas. To finance this promotion with ISMS or IAA current operating funds, while the Student Loan Fund has accumulated interest and penalty income lying dormant in government notes, is not the most effective investment of resources.

The joint committee discussed the possible ways to communicate to medical students, interns and residents regarding the attractiveness of Illinois as a location for a rewarding practice and home-life. A well-made film depicting the quality of life for the average practitioner in rural Illinois, including the sophisticated facilities and variety of medical experience would do an outstanding job of carrying this message. There is no such film available at the present time, and the committee agreed that the expenditures of funds to help support such a film would be a worthwhile investment. Foundations, farm implement manufacturers, and pharmaceutical corporations are just a few of the potential types of co-sponsors for this type of project, and it was agreed that contacts with potential contributors should be initiated. Trust fund accumulated income in excess of current student loan requests should be available for additional efforts in support of the program's purpose. Official medical school support and participation in the film would be a valuable addition to its impact.

Although the original trust agreement between the First National Bank of Chicago, ISMS and IAA provides only for loans to students, the possibility of utilizing a portion of accumulated investment income for other efforts, leaving original principal contributions intact, could be achieved by agreement amendment.

A new paragraph should be added to the Trust agreement, stating that one of the purposes of the fund is to disseminate information encouraging the location of doctors in rural communities and that the Loan Fund Board may direct the use of the funds for such purposes.

For the first time in many years, all ten of the Committee's recommendations for admission were later accepted by the University's medical college admission committee. Substantial credit for this achievement must go to ISMS President Philip G. Thomsen, who has labored so consistently and persuasively for this official school support for rural medical practice through this IAA/ISMS program.

National Conference on Rural Health

Donald E. Stehr, member of the Rural Health Committee, attended the AMA's 21st National Conference on Rural Health held in Seattle, Washington, March 28-30, 1968.

The AMA Council on Rural Health met with state committee chairmen on March 28. At this meeting, Thomas C. Points, M.D., Ph.D., Project Coordinator of the University of Oklahoma Medical Center, gave a report on progress in Oklahoma's Project Responsibility.

State society involvement in rural health programs was discussed, and state conferences on rural health, preceptorships, and physician placement services were often-mentioned examples. Many states have special programs involving migrant workers, tractor protection, slow-moving vehicles, traffic safety, and poisons and pesticides. Medical self-help and emergency medical services are additional projects that should receive wider consideration in the future.

The Conference program included resource material

and discussion on 1) Community Health Planning, 2) Rural Emergency Medical Service, 3) The Role of Medical Education in Meeting Rural Health Needs, and 4) Community-Based Home Programs.

Medical schools can become involved in regional programs and in sponsoring community medical centers. They must provide better exposure of medical students to community care through preceptorships and new course content. Medical schools can also help in the development of paramedical personnel able to handle minor medical problems and to make informed referrals in those communities unable to support full time physicians.

Rural areas are critically deficient in home care programs. Such facilities must extend to all age groups and include acute as well as chronic illness. This is one certain item for present consideration as a part of total comprehensive community health planning.

Annual Students' Dinner

On November 15, 1968, the committee hosted its present medical school students and their wives at the annual dinner meeting. Philip G. Thomsen, MD, ISMS President, and University of Illinois Medical College graduate Ronald Johnson, addressed the students and medical society, medical school, and agricultural association officials.

Doctor Thomsen spoke informally regarding the relationship of the medical school's plans for expansion in student ranks to the medical society's program to train more physicians that will enter private practice in areas of medical need.

Ronald Johnson, a 1968 medical school graduate, addressed the group, relating his experience while on a Smithe, Kline & French Foreign Fellowship at the Karway Hospital in the Republic of Congo.

Promotion of Program Availability

Under the direction of committee member Charles N. Salesman, M.D., the Loan Fund Board communicated in 1968 with the premedical advisor of all undergraduate colleges in the Midwest and the financial affairs representative at each U. S. medical school. Availability of the loan program to all Illinois residents who would agree to practice in rural Illinois for 5 years was noted, and samples of the descriptive brochure available to each prospective applicant were provided.

Discriminatory provisions previously in the program, such as the restrictions that applicants be male and from outside of Cook County, have been eliminated. It was the Board's belief that willingness to practice in Illinois in a non-metropolitan area was sufficient indication of intent. Arbitrary exclusions of females and Cook County residents served only to reduce the available pool of qualified applicants.

Although some student interest has been displayed, there are no students in medical schools other than the University of Illinois presently receiving financial assistance under the program.

Loan Fund Financial Status

The total value of the Student Loan Fund at December 31, 1968, was \$234,366 (owned 50/50 by ISMS and the Illinois Agricultural Association). The assets of the fund at that date, compared with the preceding year, were:

12/31/68		01/08/68
\$ 85,000	U. S. Treasury Bills	\$ 75,000
138,166	2% Student Promissory Notes	131,505
6,650	Cash	16,834
4,550	Liquidating penalties due	6,550
\$234,366		\$229,889

The fund's annual income report for the past three years is as follows:

	1968	1967	1966
Receipts:			
2% interest	\$1,307	3,601	4,057
Treasury bill interest	3,591	5,190	1,893
	4,898	8,791	5,950
Expenses:			
Trust administration fee	1,417	1,360	1,320
Net income	\$3,481	7,431	4,630

Jack L. Gibbs, *Chairman*

Charles N. Salesman

Donald L. Stehr

Jacob E. Reisch, *Consultant*

COMMITTEE ON SCIENTIFIC ASSEMBLY

The Committee on Scientific Assembly held its planning meeting for the 1969 convention on October 10, 1968. "Medicine in the Seventies" was chosen as the convention theme to indicate medicine's anticipation of a new decade of progress.

Convention sites were discussed. The committee is anxious to move the convention to a new location as soon as possible, but prefers to stay in downtown Chicago rather than move to a suburban or downstate hotel. Consideration is being given to using a portion of the new McCormick Place which is scheduled for completion in 1971.

Section leaders requested that \$300 be allocated to each for program expenses and honoraria. This request was forwarded to the Finance Committee which agreed to approve up to that amount per section, but that it could not allocate a flat amount to each.

The committee considered a proposal to conduct some closed circuit television programs during the convention but decided that such programs might duplicate the Illinois Surgical Society's wet clinics at Cook County Hospital. Individual sections have the option of using this type of programming if they desire.

Although there are no general scientific sessions scheduled outside of those planned by the various specialty sections, some effort has been made to provide programs that might be of broad interest. In this connection a film on Heart Transplants has been obtained for showing and several programs of a socio-economic nature are being scheduled.

Robert T. Fox, *Chairman*

J. Robert Thompson, *Director of Exhibits*

Coye C. Mason, *Assistant Director, Exhibits*

George E. Block

Charles P. McCartney

John J. Brosnan

Harold P. McGinnes

Robert R. Fahringer

Donald L. Unger

Auxiliary Representatives

Mrs. John Van Prohaska

Mrs. Maurice Goldstein

SCIENTIFIC SECTION CHAIRMAN

Allergy—Donald B. Frankel

Dermatology—Malcolm C. Spencer

E.E.N.T.—E. Skolnick

Internal Medicine—Angelo P. Creticos

Neurology & Psychiatry—David Swanson

Obstetrics & Gynecology—Wm. R. Roach

Pathology—Elizabeth A. McGrew

Pediatrics—Ira M. Rosenthal

Physical Medicine & Rehabilitation—W. T. Liberson

Preventive Medicine & Public Health—Roger F. Sondag

Radiology—Richard E. Buenger

Surgery—Roderick H. Maguire

Resolutions

RESOLUTION 69M-1

Introduced by: Harold C. Lueth, for the Committee on Disaster Medical Care

Subject: PACKAGED DISASTER HOSPITALS

Referred to: Reference Committee on Public Relations & Miscellaneous Business

WHEREAS, Packaged disaster hospitals comprise a major source of hospital medical care capability in the United States and

WHEREAS, The PDH units are stored primarily in non-target areas while the majority of existing hospital beds are located in target areas, and therefore subject to destruction in event of national disaster; and

WHEREAS, Both the PDH and natural disaster hospital (NDH) are major sources for the care of disaster casualties and

WHEREAS, The establishment, storage and maintenance of the PDH and NDH require considerable training beyond that of physicians and nurses for the performance of their ordinary medical functions and

WHEREAS, ISMS has played a major role in PDH and NDH training programs, now therefore be it

RESOLVED, That ISMS strongly support the PDH and NDH programs, to include training, in all Illinois hospitals. Be it further

RESOLVED, That ISMS urge the Illinois Hospital Association and medical staffs of its component member hospitals to cooperate in personnel training for such program and in the storage of PDH and NDH units. Be it further

RESOLVED, That ISMS urge support by hospital medical staffs for the Hospital Reserve Disaster Inventory Program, one in which the federal government furnishes expendable supplies to hospitals at no cost, to augment their supplies in case of disaster.

RESOLUTION 69M-2

Introduced by: Chicago Medical Society

Subject: ISMS MEMBERSHIP FOR OSTEOPATHS

Referred to: Reference Committee on Officers and Administration

Fred A. Tworoger, *chairman*

WHEREAS, The American Medical Association suggests that each county and state medical society may accept qualified doctors of osteopathy as active members of our medical society, and

WHEREAS, The House of Delegates of the American Medical Association, meeting in Miami in December 1968, adopted a report of the Board of Trustees of the American Medical Association to "Assure the provision of the best possible care of the American people; make available to students and graduates in osteopathy, education of the same high standards as prevail in undergraduate and continuing educational programs in medicine; provide avenues whereby qualified osteopaths may be assimilated into the mainstream of medicine;" and

WHEREAS, These objectives can only be achieved by accepting osteopaths who are qualified by licensure to practice medicine and surgery in all its branches in the State of Illinois, as members of the Chicago Medical Society, therefore be it

RESOLVED, That qualified doctors of osteopathy meeting all qualifications for membership in the Chicago Medical Society be so accepted as active members of our Society, and be it further

RESOLVED, That the Illinois State Medical Society be advised of this action so that other county societies be similarly guided.

RESOLUTION 69M-3

Introduced by: Chicago Medical Society

Subject: HEALTH CARE FINANCING

Referred to: Reference Committee on Economics and Insurance

Clarence A. Norberg, *Chairman*

WHEREAS, Expansion of the Medicare program is not economically feasible, and

WHEREAS, The medical profession should act in a constructive manner, now therefore be it

RESOLVED, That the private health insurance carriers be encouraged to form a COMSTAT type of national health corporate structure for the purpose of delivering health care financing to the nation; that the physician be paid on a fee-for-service basis, which is the usual and customary charge; that should any profits accrue from such corporate structure, the profits be distributed to the medical schools existing or contribute to the capitalization of the now needed new medical schools.

RESOLUTION 69M-4

Introduced by: Will-Grundy County Medical Society

Subject: ISMS RESERVE FUND

Referred to: Reference Committee on Finances, Budgets and Publications

William Hill, *Chairman*

WHEREAS, In 1966 the House of Delegates raised the dues and allotted \$8 yearly for developing a reserve fund, and

WHEREAS, No specific limit was placed upon this fund, and

WHEREAS, These funds will total more than \$400,000 in 1969, and

WHEREAS, This is a large sum of money which is not of any particular use at the present time to the Illinois State Medical Society, and

WHEREAS, Each year before the House of Delegates there are programs and problems which arise requiring money for developing, be it therefore

RESOLVED, That the reserve fund be maintained at its present level and future uses of these monies be allocated to more constructive programs, such as: medical and post graduate educations; preceptorships; desirable social programs; and advancement of county or multi-county, medical society administrative offices.

RESOLUTION 69M-5

Introduced by: Will-Grundy County Medical Society
Subject: COUNTY MEDICAL SOCIETY ADMINISTRATIVE OFFICES

Referred to: Reference Committee on Officers and Administration

Fred A. Tworoger, *Chairman*

WHEREAS, These are extremely troubled times in the practice of medicine and in the maintenance of the integrity of the patient-doctor relationship, and

WHEREAS, Medicine is well organized at its upper levels, but may be less organized at its lowest eschelons, and

WHEREAS, Organized medicine in the State of Illinois can only be as effective as the sum total of its individual county medical societies, and

WHEREAS, Practicing physicians, who are extremely busy individuals, can only be effective as officers of their county medical society when there is personal sacrifice, and

WHEREAS, The efficiency and efficacy of the committees of the Illinois State Medical Society, when requiring action of individual county medical societies and individual physicians, are sharply curtailed because of lack of administrative organization at the local level, and

WHEREAS, The increased efficiency and effectiveness of lay administrative offices has been dramatically demonstrated to the Will-Grundy County Medical Society when such organization occurred in coordination with two other professional societies, and

WHEREAS, The Illinois Medical Society studied the matter and in 1967 a detailed report was made but no definitive action was taken, be it therefore

RESOLVED, That the Illinois State Medical Society again direct its efforts toward the goal of aiding every county medical society in the State of Illinois in obtaining a lay administrative office either in conjunction with other neighboring medical societies or other professional societies, and be it further

RESOLVED, That the Illinois delegates to the American Medical Association House of Delegates be encouraged to stimulate the American Medical Association to aid in similarly organizing other component societies, and be it further

RESOLVED, That monies for this study and initial financial support to the several county medical societies wishing to obtain administrative staff be acquired from the dues assessed for the reserve funds.

RESOLUTION 69M-6

Introduced by: Will-Grundy County Medical Society
Subject: DEVELOPMENT OF PRECEPTORSHIP PROGRAMS
Referred to: Reference Committee on Finances, Budgets and Publications

William Hill, *Chairman*

WHEREAS, The Senior Medical Student Preceptorship Program has met with success in DuPage County, and

WHEREAS, There are many medical students that do not have the advantage of such a program, be it therefore

RESOLVED, That the Illinois State Medical Society support and advance in all Illinois Medical Schools the SENIOR PRECEPTORSHIP PROGRAM, and that the several county medical societies be given the opportunity to assist in the clinical instruction of these students, and be it further

RESOLVED, That funding, if needed, be obtained from dues assessed for the reserve fund.

RESOLUTION 69M-7

Introduced by: DuPage County Medical Society
Subject: MEDICAL SCHOOL CURRICULUM TO INCLUDE COURSE IN PATIENT CARE COSTS

Referred to: Reference Committee on Scientific Service and Medical Education

Don L. Ervin, *Chairman*

WHEREAS, Newly trained physicians are primarily academically oriented, and

WHEREAS, There is an ever increasing concern regarding rising patient care costs, and

WHEREAS, The recent and highly trained physicians who are being produced by the medical schools have no apparent awareness of the cost of patient care, therefore be it

RESOLVED, That a course in patient care costs should be a required part of the curriculum of the medical schools in the State of Illinois, and be it further

RESOLVED, That the Illinois State Medical Society proceed to the American Medical Association House of Delegates at its next annual meeting with a similar resolution for all medical schools.

Additional resolutions will be sent to all delegates as they are received. If possible, they will also be published in the May issue of "Pulse."

Late Reports:

EIGHTH DISTRICT

The past year has been unusually quiet in the Eighth District.

A new plan for payment of Medicare bills is being utilized in Clark County. A report of the results of this mode of collection will be made at the time of the Annual meeting of the I.S.M.S.

Two representatives from Blue Cross-Blue Shield appeared before the doctors of Crawford County and explained the authority vested in them by HEW to request records of patients confined to hospitals under Medicaid. The problem was resolved between the physicians and representatives by discussion.

The clinic in Olney requested assistance to help a physician from Kentucky procure his Illinois license so that

he might become a member of that group. This was done and he is currently practicing in Olney.

In March, 1969, President Philip G. Thomsen of the I.S.M.S. came to Champaign and addressed the officers, delegates and members of the Eighth District at an evening dinner. His topic was "The Shortage of Physicians in Illinois." State Representative Charles W. Clabaugh also addressed the assemblage on the same topic.

There was a workshop held during that afternoon on Government Health Programs. This was sponsored by the State Society and the Illinois Medical Service. It was attended by 152 physicians and their medical aides. The evening address by Dr. Thomsen was attended by 130 persons.

W. H. Schowengerdt, *Trustee*

"Medicine in the 70's"

Program Summary

1969 Annual ISMS Convention

SATURDAY, MAY 17

Noon	Board of Trustees Luncheon	Gold Room 114
2:00 p.m.	Board of Trustees Meeting	Crystal Room
6:00 p.m.	Board of Trustees Dinner	Gold Room 114
6:00 p.m.	AMA Delegation Dinner	Orchid Room 106
6:00 p.m.	Past Presidents Dinner	

SUNDAY, MAY 18

9:00 a.m.	Registration of Officers and Delegates	Mezzanine
10:00 a.m.	Reference Committee Chairmen	French Room 107
10:00 a.m.	District Meetings	
1:00 p.m.	1969 Conference on Hospital Cancer Programs	Louis XVI Room
2:00 p.m.	Credentials Committee	Executive Ballroom Foyer
3:00 p.m.	House of Delegates	Executive Ballroom
5:30 p.m.	Delegates Buffet	Louis XVI Room
6:00 p.m.	Illinois Obstetrical and Gynecological Society Board Dinner	Gold Coast Room 111
7:00 p.m.	Reference Committees Officers and Administration	Holiday Room 105
	Finances, Budgets, and Publications	Ruby Room 113
	Constitution and By-laws	French Room 107
	Economics and Insurance	Gold Room 114
	Legislation and Public Affairs	Old Chicago Room 101
	Scientific Services and Medical Education	Crystal Room
	Public Relations and Miscellaneous Business	Life Room 108

MONDAY, MAY 19

8:00 a.m.	Registration	Mezzanine
8:00 a.m.	Board of Trustees Breakfast	French Room 107
8:00 a.m.	Illinois Surgical Society	Cook County Hospital
8:30 a.m.	Illinois OB-GYN Society Meeting	Crystal Room
9:00 a.m.	Symposium on Alcoholism	Ruby Room 113

11:00 a.m.	Official Opening of Exhibits	
Noon	Illinois OB-GYN Society Luncheon	Gold Room 114
1:00 p.m.	Section on Neurology and Psychiatry	Louis XVI Room
1:30 p.m.	Section on Surgery & Illinois Surgical Society	Executive Ballroom
4:00 p.m.	IMPAC Annual Meeting	Gold Room 114
5:00 p.m.	Exhibits Close	
6:00 p.m.	Public Affairs Reception & Dinner	Bal Tabarin

TUESDAY, MAY 20

8:00 a.m.	Board of Trustees Breakfast	French Room 107
8:00 a.m.	Registration	Mezzanine
8:30 a.m.	Section on Allergy	Gold Room 114
9:00 a.m.	Section on OB-GYN	Ruby Room 113
9:00 a.m.	Exhibits open	
10:30 a.m.	Symposium on Peripheral Vascular Abnormalities	Life Room 108
Noon	Fifty Year Club Luncheon	Louis XVI Room
12:30 p.m.	Preventive Medicine & Public Health Luncheon	French Room 107
12:50 p.m.	Continuing Education Program in Psychiatry for Physicians in Private Practice	Old Chicago Room 101
1:30 p.m.	Section on Radiology	Crystal Room
1:30 p.m.	Section on Physical Medicine & Rehabilitation	Gold Room 114
1:30 p.m.	Credentials Committee	Executive Ballroom Foyer
2:00 p.m.	House of Delegates	Executive Ballroom
2:00 p.m.	Section on Public Health and Preventive Medicine	Ruby Room 113
5:00 p.m.	Exhibits Close	
6:00 p.m.	Illinois Society of Pathologists Reception & Dinner	Ruby Room 113
6:00 p.m.	President's Reception & Dinner	Grand Ballroom
6:00 p.m.	University of Illinois Alumni Dinner	Louis XVI and Crystal Rooms

WEDNESDAY, MAY 21

8:00 a.m.	Board of Trustees Breakfast	French Room 107	12:30 p.m.	Illinois Society of Internal Medicine Luncheon	French Room 107
8:00 a.m.	Registration	Mezzanine			
8:30 a.m.	Section on Pathology	Old Chicago Room 101	12:30 p.m.	Illinois Academy of General Practice Luncheon	Old Chicago Room 101
8:30 a.m.	Traveling Seminar on ECFs and Homes for the Aged	Registration Area	12:30 p.m.	Illinois Chapter American Academy of Pediatrics Luncheon	Life Room 108
9:00 a.m.	Section on EENT	Ruby Room 113			
9:00 a.m.	Section on Pediatrics	Louis XVI Room	12:30 p.m.	Dermatology Luncheon	Crystal Room
9:00 a.m.	Section on Internal Medicine and Illinois Society of Internal Medicine	Gold Room 114	1:00 p.m.	Symposium on Learning and Reading Problems	Ruby Room 113
9:00 a.m.	Exhibits Open		1:00 p.m.	Workshop on Financial Planning	Louis XVI Room
9:30 a.m.	Section on Dermatology	Crystal Room	1:30 p.m.	IAGP Board Meeting	Orchid Room 106
9:30 a.m.	Credentials Committee	Executive Ballroom Foyer	5:00 p.m.	Exhibits Close	
10:00 a.m.	House of Delegates	Executive Ballroom	6:00 p.m.	Board of Trustees Dinner	Randolph Room

HOUSE OF DELEGATES MEETING *Executive Ballroom*

Sunday, May 18	3:00 p.m.
Tuesday, May 20	2:00 p.m.
Wednesday, May 21	10:00 a.m.

REFERENCE COMMITTEE MEETINGS

Sunday, May 18	7:00 p.m.
Officers and Administration	Holiday Room 105
Constitution and By-Laws	French Room 107
Finances, Budgets and Publications	Ruby Room 113
Legislation and Public Affairs	Old Chicago Room 101
Scientific Services and Medical Education	Crystal Room
Economics and Insurance	Gold Room 114
Public Relations and Miscellaneous Business	Life Room 108

BOARD OF TRUSTEES MEETINGS

Saturday, May 17	Noon	Gold Room 114
Saturday, May 17	2:00 p.m.	Crystal Room
Monday, May 19	8:00 a.m.	French Room 107
Tuesday, May 20	8:00 a.m.	French Room 107
Wednesday, May 21	8:00 a.m.	French Room 107
Wednesday, May 21	6:00 p.m.	Randolph Room

Program is acceptable for 24 elective hours by the American Academy of General Practice

Calls Will Reach You Easily at the '69 Convention

Doctor, please inform your staff that while you are attending the ISMS Convention, you may be reached through the Physician's Message Center from 2:00 p.m. to 5 p.m., Sunday, and from 9:00 a.m. to 5:00 p.m., Monday, Tuesday, and Wednesday. Here is the number to remember:

312-332-5735

This is a direct connection which will not go through the hotel switchboard.

Convention Program by Days

ILLINOIS SURGICAL SOCIETY

Monday, May 19 **Cook County Hospital**
Reginald M. Norris, M.D.
Chairman of Surgical Symposium

8:00-10:30 a.m. **Surgical Amphitheater**
"Selective Vagotomy"
Moderator: Armand Littman, M.D., Professor of Medicine, University of Illinois; Chief, Medical Service, Veterans Administration Hospital, Hines
Surgeon: Lloyd M. Nyhus, M.D., Professor and Chairman, Department of Surgery, University of Illinois College of Medicine
Panelists: William J. Gillesby, M.D., Associate Clinical Professor of Surgery, University of Illinois College of Medicine; William Requarth, M.D., Clinical Professor of Surgery, University of Illinois College of Medicine

8:00-10:30 a.m. **Operating Room "A"**
"Surgery of the Biliary Tract"
Moderator: Charles B. Puestow, M.D., Professor of Surgery, University of Illinois College of Medicine
Surgeon: James R. Hines, M.D., Assistant Professor of Surgery, Northwestern University Medical School
Panelists: Michael J. Russo, M.D., Surgeon, Champaign; Ward H. Eastman, M.D., Clinical Assistant Professor of Surgery, University of Illinois College of Medicine

8:00-10:30 a.m. **Operating Room "B"**
"Colon Surgery"
Moderator: John M. Beal, M.D., Professor and Chairman, Department of Surgery, Northwestern University Medical School
Surgeon: Peter A. Rosi, M.D., Professor of Surgery, Northwestern University Medical School
Panelists: Robert E. Condon, M.D., Associate Professor of Surgery, University of Illinois College of Medicine; Frederic A. de Peyster, M.D., Associate Clinical Professor of Surgery, University of Illinois College of Medicine

8:00-10:30 a.m. **Operating Room "C"**
"Thoracic Surgery"
Moderator: Jack C. Cooley, M.D., Assistant Professor of Surgery, University of Illinois College of Medicine, and Chief, Department of Surgery, Carle Clinic and Hospital, Urbana
Surgeon: Walter L. Barker, M.D., Assistant Professor of Surgery, University of Illinois College of Medicine
Panelists: Robert A. Harp, M.D., Memorial Hospital, Springfield; Thomas W. Samuels, Jr., M.D., Assistant Professor of Surgery, Loyola University Stritch School of Medicine

8:00-10:30 a.m. **Operating Room "D"**
"Vascular Surgery"
Moderator: Robert J. Freeark, M.D., Professor of Surgery, Northwestern University Medical School, and Director, Cook County Hospital, Chicago
Surgeon: John J. Bergan, M.D., Assistant Professor of Surgery, Northwestern University Medical School
Panelists: Jack L. Gibbs, M.D., Chairman, Department of Surgery, Graham Hospital, Canton; Gustav W. Giebelhausen, M.D., Chief of Surgery, Proctor Hospital, Peoria

8:00-10:30 a.m. **Hektoen Institute—Laboratory**
"Demonstration of Causes of, and Therapy for, Cardiac Arrest"
Vincent Collins, M. D., Professor of Surgery, Northwestern University Medical School; Milton Weinberg, Jr., M.D., Associate Professor of Surgery, University of Illinois College of Medicine

11 a.m.-12 Noon **Hektoen Institute Auditorium**
Grand Rounds
Curtis P. Artz, M.D., Professor and Chairman, Department of Surgery, Medical College of South Carolina, Charleston, S. Car.

Members of the Medical Profession are Invited to Sessions
NO REGISTRATION FEE

ILLINOIS OBSTETRICAL & GYNECOLOGICAL SOCIETY

Monday, May 19 **Crystal Room**
Chairman: John S. Hipskind, M.D.

8:30 a.m. Business Meeting of the Illinois Obstetrical & Gynecological Society
Dean M. Farley, M.D., Presiding

9:00 a.m. "Chronic Cystic Mastitis"
Thomas R. Wilson, M.D., Carle Clinic, Urbana

9:30 a.m. "Hematologic Problems in Pregnancy"
Thomas N. Gynn, M.D., Chairman, Department of Hematology, St. Francis Hospital, Evanston

10:00 a.m. Case Report

10:30 a.m. Exhibit Break

10:45 a.m. "Caudal Anesthesia in Private Obstetrical Practice"
Donald L. Grieme, M.D., Galesburg

11:15 a.m. "Cone-Cryostate Cervical Biopsy in the Small General Hospital"
Matt H. Backer, Jr., M.D., Associate Professor, Department of Gynecology & Obstetrics, St. Louis University School of Medicine, St. Louis, Mo.

Noon Luncheon **Gold Room 114**

1:00 p.m. "Morphological Effects of Intrauterine Devices on the Endometrium"
Ralph M. Wynn, M.D., Professor and Chairman, Department of Obstetrics & Gynecology, University of Illinois Medical Center, Chicago.

1:45 p.m. "Vaginal Surgery for Non-Malignant Gynecologic Conditions"
Abraham F. Lash, M.D., Ph.D., Director, Division of Obstetrics & Gynecology, Cook County Hospital, Professor Emeritus, Northwestern University

2:30 p.m. Exhibit Break

2:45 p.m. "What the Physician Should Know About Human Sexuality"
Beverly T. Mead, M.D., Professor and Chairman, The Creighton University, School of Medicine, Department of Psychiatry, Omaha, Nebraska

PHYSICIAN'S MEDICAL MANAGEMENT OF ACUTE ALCOHOLISM

Monday, May 19 **Ruby Room 113**
9:00 a.m.

SECTION ON NEUROLOGY & PSYCHIATRY

Monday, May 19 **Louis XVI Room**

Chairman: David W. Swanson, M.D., Chicago
PSYCHIATRY: PSYCHIATRIC DISORDERS IN THE PHYSICIAN

1:00 p.m. "Addiction in the Medical Professions"
 Alex J. Spadoni, M.D., Clinical Assistant Professor, Department of Psychiatry & Neurology, Loyola University, Stritch School of Medicine, Hines

1:30 p.m. Discussion

1:45 p.m. "Why Physicians Commit Suicide"
 Paul H. Blachly, M.D., Associate Professor, Department of Psychiatry, University of Oregon Medical School, Portland, Ore.

2:15 p.m. Discussion

2:30 p.m. Exhibit Break

NEUROLOGY: PEDIATRIC NEUROLOGY

3:00 p.m. "Brain Damage—Perceptual & Motor Handicaps"
 Edward Page-El, M.D., Director, Outpatient Department, Illinois Pediatric Institute; Assistant Professor, Department of Pediatrics, University of Illinois College of Medicine, Chicago, and Herbert J. Grossman, M.D., Director, Illinois Pediatric Institute; Professor, Department of Pediatrics, University of Illinois College of Medicine, Chicago.

3:30 p.m. Discussion

3:45 p.m. "Relationship of Sex Chromosome Abnormalities and Neuropsychiatric Disorder"
 Janet D. Rowley, M.D., Research Associate and Assistant Professor, Department of Medicine, University of Chicago, Pritzker School of Medicine, Chicago

SECTION ON SURGERY & ILLINOIS SURGICAL SOCIETY

Monday, May 19 **Executive Ballroom**
 Chairman: Roderick Maguire, M.D., Canton

1:30-2:30 p.m. "Inflammatory Diseases of the Bowel"
 Moderator: George E. Block, M.D., Professor of Surgery, and Chief, Section of Head and Neck Surgery, University of Chicago, Pritzker School of Medicine
 Panelists: Joseph B. Kirsner, M.D., Louis Block Professor of Medicine, and Chief, Section of Gastroenterology, University of Chicago, Pritzker School of Medicine; R. Kennedy Gilchrist, M.D., Professor of Surgery, University of Illinois College of Medicine; John W. Howser, M.D., Professor of Surgery, Cook County Graduate School of Medicine

2:30-3:30 p.m. "Duodenal Ulcer"
 Curtis P. Artz, M.D., Professor and Chairman, Department of Surgery, Medical College of South Carolina, Charleston, S. C.

3:30-4:30 p.m. "Management of Abdominal Trauma"
 Moderator: Robert J. Baker, M.D., Professor of Surgery, University of Illinois College of Medicine, and Director, Division of Surgery, Cook County Hospital
 Panelists: Robert J. Freemark, M.D., Professor of Surg-

ery, Northwestern University Medical School; Irving Bush, M.D., Professor and Chairman, Department of Urology, Chicago Medical School; Glen D. Dobben, M.D., Associate Professor, Department of Radiology, University of Chicago, Pritzker School of Medicine

IMPAC ANNUAL MEETING

Monday, May 19 **Gold Room 114**
4:00 p.m.

PUBLIC AFFAIRS DINNER CAMP MEMORIAL LECTURE

Monday, May 19 **Bal Tabarin**

6:00 p.m. Reception & Dinner

8:00 p.m. Camp Memorial Lecture
 Sen. Robert Packwood (R.-Ore.)

SECTION ON ALLERGY

Tuesday, May 20 **Gold Room 114**
 Chairman: Donald B. Frankel, M.D., Chicago

8:30 a.m. "Rhino cytology & Its Diagnostic Possibilities in Allergy"
 Lucia T. Fisher-PAP, M.D., Clinical Instructor in Medicine, University of Illinois

9:00 a.m. "Practical Aspects of Developmental Immunology"
 Morad Jacobson, M.D., Assistant Professor of Pediatrics, University of Illinois College of Medicine

9:30 a.m. "Newer Drugs in the Treatment of Asthma"
 Philip S. Norman, M.D., Associate Professor of Medicine, Division of Allergy & Infectious Disease, Johns Hopkins University Hospital, Baltimore, Md.

10:30 a.m. Exhibit Break

11:00 a.m. "Adrenergic Agents in Allergic Disease"
 Ramond Camilo, M.D.

11:30 a.m. "Treatment of the Moribund Asthmatic"
 Morton Shulman, M.D., Assistant Professor of Anesthesiology, University of Illinois, College of Medicine

SYMPOSIUM ON PERIPHERAL VASCULAR ABNORMALITIES

Tuesday, May 20 **Life Room 108**
10:30 a.m.

with complimentary buffet luncheon following
 The above program is presented with the assistance of USV Pharmaceutical Corporation.

SECTION ON OBSTETRICS & GYNECOLOGY

Tuesday, May 20 **Ruby Room 113**
 Chairman: William R. Roach, M.D., Chicago

9:00 a.m. "Blood Mass Redistribution in Hypertensive & Hypotensive Disorders of Pregnancy"
 Josef Bierniaz, M.D., Attending Obstetrician, Michael Reese Hospital, Chicago

9:30 a.m. "Pelvic Pain—Problems Encountered in Diagnosis & Treatment"
 Frederick P. Zuspan, M.D., Professor & Chairman, Department of Obstetrics & Gynecology, University

10:00 a.m. "Laparoscopy"

John Barton, M.D., Director of Obstetrical & Gynecological Education, Cook County Hospital, Chicago.

10:30 a.m. "Functional Interpretation of Placental Ultrastructure"

Ralph M. Wynn, M.D., Professor & Head of Department of Obstetrics & Gynecology, University of Illinois, College of Medicine

11:30 a.m. "Modern Trends in Irradiation Therapy of Pelvic Cancer"

William Brand, M.D., Department of Radiation Therapy, Wesley Memorial Hospital, Chicago.

FIFTY-YEAR CLUB LUNCHEON

Tuesday, May 20

Louis XVI Room

12:00 noon Luncheon

PUBLIC HEALTH LUNCHEON

Tuesday, May 20

French Room 107

Presiding: R. F. Sondag, M.D., Chairman, Springfield (Illinois Academy of Preventive Medicine jointly with the Section on Preventive Medicine & Public Health, Illinois Chapter—American Association of Public Health Physicians, and Illinois Association of Medical Health Officers.)

OPEN TO ALL PHYSICIANS

12:00 noon Luncheon

"Medicine in the Seventies—Congressional Viewpoint"
Congressman Durward G. Hall

**SECTION ON PREVENTIVE MEDICINE
& PUBLIC HEALTH**

Tuesday, May 20

Ruby Room 113

Chairman: R. F. Sondag, M.D., Springfield

2:00 p.m. Panel Discussion

Congressman Durward G. Hall

**CONTINUING EDUCATION
PROGRAM IN PSYCHIATRY
FOR PHYSICIANS IN PRIVATE PRACTICE**

(Sponsored by the Department of Psychiatry and Neurology of The Chicago Medical School. Program Chairman: John Cowen, M.D., Clinical Professor of Psychiatry at The Chicago Medical School and Staff Psychiatrist of the Hines Veteran's Administration Hospital.)

Tuesday, May 20

Old Chicago Room 101

12:50 p.m. Introduction

"The Continuing Education Program"

H. H. Garner, M.D., Professor and Chairman, Dept. of Psychiatry and Neurology, The Chicago Medical School and Mt. Sinai Hospital.

1:00 p.m. "Some Comments on Psychopathology in Adolescence, Drugs and Psychopharmacology."

Oscar Davis, M.D., Ph.D., Clinical Associate Professor of Psychiatry and Pharmacology, The Chicago Medical School

Community Psychiatry

1:45 p.m. Open Discussion

2:00 p.m. Reply

2:15 p.m. Break

2:30 p.m. "People & Drugs"

Paul David, M.D., Clinical Associate Professor of Psychiatry, The Chicago Medical School.

3:45 p.m. Open Discussion

4:00 p.m. Reply

SECTION ON RADIOLOGY

Tuesday, May 20

Crystal Room

Chairman: Richard Buenger, M.D., Chicago

1:30 p.m. "Angiographic Evaluation of Abdominal Diseases"

Klaus Ranniger, Professor of Radiology, University of Chicago

2:30 p.m. Exhibit Break

3:00 p.m. Panel Discussion

4:30 p.m. Business Meeting of the Illinois Chapter of the American College of Radiology

5:00 p.m. Reception

**SECTION ON PHYSICAL MEDICINE &
REHABILITATION**

Tuesday, May 20

Gold Room 114

Chairman: W. T. Liberson, M.D., Ph.D., Chicago

PHYSICAL MEDICINE & REHABILITATION IN THE SEVENTIES

"The Past, Present, and Future of Physical Medicine and Rehabilitation as a Part of Comprehensive Medical Care"

1:30 p.m.

"Delivery of Rehabilitation Services in the Seventies"

Sidney Licht, M.D., Past-President of the American College of Rehabilitation Medicine; Curator, Physical Medicine Collection, Yale Medical Library, Yale University, New Haven, Conn.

"Delivery of Rehabilitative Services in the Seventies"

Jerome W. Gersten, M.D., Professor & Chairman, Department of Physical Medicine and Rehabilitation, University of Colorado School of Medicine, Denver; President-Elect of the American Congress of Rehabilitation Medicine

"Cardiac Rehabilitation

Jerome S. Tobis, M.D., Professor, Department of Physical Medicine and Rehabilitation, Albert Einstein College of Medicine, New York; Chief, Division of Rehabilitation Medicine, Montefiore Hospital & Medical Center, New York; Past-President of the American Congress of Rehabilitation Medicine

"New Operant Conditioning Techniques in Rehabilitation Medicine"

James D. Block, Ph.D., Associate Professor, Department of Pediatrics, Neuropsychological Laboratory, Department of Pediatrics, New York Medical College, New York

"Electroneuroprosthesis: History and Forecast"

Wendell J. S. Krieg, Ph.D., Professor of Anatomy, Department of Biostructure, Northwestern University Medical School, Chicago

"Physical Medicine & Rehabilitation Technology in the Seventies"

W. T. Liberson, M.D., Ph.D., Professor of Pharmacology, Loyola University School of Medicine, and Veterans' Administration Hospital, Hines; Consultant, Little Company of Mary Hospital, Evergreen Park

Annual Banquet

6:00 p.m.

Grand Ballroom

TRAVELING SEMINAR ON ECFs AND HOMES FOR THE AGED

Wednesday, May 21

8:15 a.m.

Assemble at Convention Registration Desk, Mezzanine

SECTION ON E.E.N.T.

Wednesday, May 21

Ruby Room 113

Chairman: E. M. Skolnik, M.D.

8:30 a.m. "Lump in Throat"

A. H. Andrews, Jr., M.D., Professor of Bronchoesophagology at University of Illinois

David Caldarelli, M.D., Assistant in Otolaryngology, University of Illinois, College of Medicine

"Swelling in the Neck"

E. M. Skolnik, M.D., Professor of Otolaryngology, University of Illinois

"Serous Otitis Media: Present Concepts of Management"

Richard A. Buckingham, M.D., Clinical Professor of Otolaryngology, University of Illinois

"Facial Plastics and Reconstruction in Head and Neck Surgery"

Panel Discussion and Subjects to be covered:

Blepharoplasty
Surgery of the Aging Face
Traumatic Defects
Induced Defects
Pharyngeal Flaps

Panelists:

E. M. Skolnik, M.D., Moderator
George Sisson, M.D., Chairman and Professor of Otolaryngology and Maxillo Facial Surgery, Head of Department at Northwestern University;
Robert Eberle, M.D., Assistant Professor of Otolaryngology, University of Chicago;
Mark N. Saberman, M.D., Clinical Instructor in Otolaryngology, University of Illinois
M. Eugene Tardy, Assistant Professor of Otolaryngology, University of Illinois;
Louis T. Tenta, Assistant Professor of Otolaryngology, University of Illinois

SECTION ON PEDIATRICS

Wednesday, May 21

Louis XVI Room

Chairman: Ira M. Rosenthal, M.D., Chicago
Moderator: James Conner, M.D., Hinsdale

9:00 a.m. "Assisted Respiration in the Treatment of Severe Status Asthmaticus in Children"

Morton Shulman, M.D., Assistant Professor of Anesthesiology, University of Illinois College of Medicine, Chicago.

9:30 a.m. "A New Look at Parenteral Nutrition in Pediatrics"

Marvin Glicklich, M.D., Associate Clinical Professor of Surgery, Marquette Medical School, Milwaukee, Wis.

10:00 a.m. Exhibit Break

10:30 a.m. "Advances in the Diagnosis and Treatment of Pylonephritis in Childhood"

Clark D. West, M.D., Professor of Pediatrics, University of Cincinnati; Associate Director, Childrens' Hospital Research Foundation, Cincinnati, Ohio (Dr. West's participation is sponsored by a grant from Mead Johnson Company.)

11:15 a.m. "Circulatory Changes During Asphyxia in the Fetus and Newborn"

Richard Behrman, M.D., Professor of Pediatrics, University of Illinois College of Medicine.

11:45 a.m. "White House Conference on Children & Youth, 1970"

Ralph H. Kunstadter, M.D., Associate Professor of Pediatrics, Northwestern University Medical School, Member, Illinois Commission on Children.

SECTION ON DERMATOLOGY

Wednesday, May 21

Crystal Room

Chairman: Malcolm C. Spencer, M.D., Danville

9:00 a.m. "Anovulatory Pill Chloasma, A Simplified Treatment"

Malcolm C. Spencer, M.D., Danville, Assistant Professor of Dermatology, Northwestern University School of Medicine, Chicago.

9:20 a.m. "Confusing & Significant Oral Mucous Membrane Lesions"

Harold O. Perry, M.D., Consultant in Dermatology, Mayo Clinic, Associate Professor of Dermatology, Mayo Graduate School of Medicine, Rochester, Minn.

9:40 a.m. "Transepithelial Elimination, A Clinicopathological Study of Related Disorders"

Amir H. Mehregan, M.D., Clinical Assistant Professor of Dermatology, Wayne State University, Detroit, Mich.

10:00 a.m. "Primary Herpes Simplex Infections"

Clayton E. Wheeler, Jr., M.D., Professor of Dermatologic Medicine, University of North Carolina School of Medicine, Chapel Hill, N.C.

10:20 a.m. Exhibit Break

10:30 a.m.

Panel: "Stump the Experts"

Organizer: Lawrence Solomon, M.D., FRCP, Assistant Professor of Dermatology, University of Illinois College of Medicine, Chicago; Acting Director, Illinois Research & Educational Hospital, Chicago.

Members of the panel will be guests of the Section.

Kodachromes of interesting clinical cases will be presented by members of the section. A free exchange regarding diagnosis and management is anticipated.

12:00 noon Luncheon **Crystal Room**
Luncheon for members and guests of the Section.

"The National Program for Dermatology"

Philip C. Anderson, M.D., Associate Professor of Dermatology, University of Missouri Medical School, Columbia, Missouri.

Participation of speakers is sponsored in part by Eli Lilly & Co., Westwood Pharmaceuticals, and Merck Sharp and Dohme.

SECTION ON PATHOLOGY

Wednesday, May 21 **Old Chicago Room 101**

Chairman: Elizabeth A. McGrew, M.D., Chicago

9:00 a.m. "Automated Profiles: Uses, Abuses, Values & Problems"

Gerald G. Hoffman, M.D., Pathologist, and Jack Williams, M.D., Internist

10:30 a.m. Exhibit Break

11:00 a.m. Panel Discussion

"Automated Profiles in Chemistry, Hematology & Blood Banking"

Moderator: James E. Habegger, M.D., Vice-Pres., Illinois Society of Pathologists; President, Illinois Association of Blood Banks; Pathologist, St. Joseph's Hospital, Aurora

Participants:

Gerald G. Hoffman, M.D.

Coye C. Mason, M.D.

Luis Owano, M.D.

Jack Williams, M.D.

1:00 p.m.

Slide Seminar at the Hektoen Institute, 627 S. Wood St., Chicago.

"Pulmonary Pathology"

J. Robert Thompson, M.D.

SECTION ON INTERNAL MEDICINE & ILLINOIS SOCIETY OF INTERNAL MEDICINE

Wednesday, May 21 **Gold Room 114**

Chairmen: Angelos P. Creticos, M.D., Chicago and A. Edward Livingston, M.D., Bloomington

MEDICAL EDUCATION IN THE SEVENTIES

9:00 a.m.

"Student Expectations in Medical Education"

Nickola Novosel, student, Stritch School of Medicine

"The University and Social Needs of the Seventies"

Alexander M. Schmidt, M.D., Executive Associate Dean, College of Medicine, University of Illinois

"The Community Hospital's Contribution to Medical Education"

Herbert Bessinger, M.D., Director of Medical Education, Weiss Memorial Hospital; Clinical Associate Professor of Medicine, University of Illinois College of Medicine

"The Role of Off Campus Community Physicians in Medical Education"

E. Richard Ensrud, M.D., Carle Clinic, Champaign;

Fellow, American College of Physicians; Past President Illinois Society of Internal Medicine

"The Chicago Medical School-DuPage County Preceptorships Program"

Norman M. Frank, M.D., Clinical Associate in Medicine, Chicago Medical School

ILLINOIS SOCIETY OF INTERNAL MEDICINE

Wednesday, May 21 **French Room 107**

11:00 a.m. Reception

Noon Luncheon

1:00 p.m. Annual Meeting

Speaker: Joseph T. Painter, M.D., President-Elect, American Society of Internal Medicine.

FAMILY PHYSICIANS' LUNCHEON OF THE ILLINOIS ACADEMY OF GENERAL PRACTICE

Wednesday, May 21 **Old Chicago Room 101**

12:30 p.m. Luncheon

WORKSHOP ON FINANCIAL PLANNING

Wednesday, May 21 **Gold Room 114**

1:00 p.m.

LEARNING AND READING PROBLEMS: WHAT THE PHYSICIAN SHOULD KNOW

Wednesday, May 21 **Ruby Room 113**

1:00 p.m.

"Reading and Learning Problems—Ophthalmologists' Approach to Diagnosis and Therapy"

Lawrence J. Lawson, Jr., M.D., Evanston; Associate, Dept. of Ophthalmology, Northwestern University Medical School; Consulting ophthalmologist, Institute for Language Disorders, Northwestern University; Ophthalmologist on Task Force for Interdisciplinary Committee on Reading Problems, Center for Applied Linguistics, Washington, D.C.; Attending ophthalmologist, Evanston Hospital.

"Neurological Aspects of Learning Disabilities (Including Use of Drugs)"

D. Michael Vuckovich, M.D., Chicago; Assistant professor, Dept. of Neurology, Psychiatry, and Pediatrics, Northwestern University Medical School; Attending Neurologist, Children's Memorial Hospital and Columbus Hospital, Chicago; Consulting Neurologist, Illinois State Pediatric Institute, Institute for Juvenile Research, Chicago; and Institute for Language Disorders, Northwestern University.

"Educational Programming"

Doris Johnson, M.A., Assistant Professor of Language Pathology, Superintendent of Teacher Training in Learning Disabilities, Northwestern University, Evanston, Co-author, *Learning Disabilities: Educational Principles and Practices*.

Scientific Exhibits

S-1

- Title:** **The Effect of Fluocinolone Acetonide 0.2% in Selected Chronic Dermatoses**
Exhibitors: C. H. McCuistion, E. P. Schoch, Jr., and H. B. Christianson
Institution: Baylor Univ., Southwestern Med. School and Oschner Found. Hosp. Austin, Tex., Dallas, Tex. and New Orleans, La.
Description: This exhibit graphically and pictorially presents the results of a double-blind study using fluocinolone acetonide 0.2% and a placebo in the treatment of notoriously chronic and obstinate dermatoses. Included also are the results of a separate study comparing the effects of fluocinolone acetonide 0.2% with floucinolone acetonide 0.025%.

S-2

- Title:** **Menstrual Disorders of Adolescence**
Exhibitors: Vincent J. Capraro
Institution: . . . Buffalo, New York
Description: The physiology, etiology and treatment involved in dysmenorrhea, dysfunctional uterine bleeding, delayed menarche and secondary amenorrhea are discussed.

S-3

- Title:** **Surgical Rehabilitation of the Rheumatoid Hand**
Exhibitors: Peter Casagrande, Bernard M. Norcross and L. Maxwell Lockie
Institution: State Univ. of N.Y. at Buffalo, Buffalo Gen. Hosp., Buffalo, N.Y.
Description: About 75% of people with rheumatoid arthritis develop synovitis of the hand, finger joints and/or tendons. In some this subsides either spontaneously or upon medical treatment. In others the disease is progressive and often severely disables the hands.

The synovitis of rheumatoid arthritis is proliferative. It causes swelling of joints and tendons and destroys the joint as well as its articulating structures.

Prompt surgical removal of this destructive synovial tissue will modify or prevent many rheumatoid deformities of the hand. When deformity is established, reconstructive surgery can often improve function. Postoperatively, good medical management helps maintain such improvement.

S-4

- Title:** **Roentgen Diagnosis of Dissecting Aortic Aneurysm**
Exhibitors: William T. Meszaros and Paul Schimert
Institution: Illinois Masonic Medical Center, Chicago
Description: Dissecting aneurysms of the aorta are being diagnosed with increasing frequency. Contrary to popular belief, many patients survive the initial dissection.

Plain chest roentgenograms are frequently diagnostic. Aortography confirms the diagnosis and demonstrates the anatomic extent of the process for the surgeon.

This exhibit demonstrates the diagnostic features and the value of the roentgen examination.

S-5

- Title:** **Eye Inflammations: Their Diagnosis and Treatment**
Exhibitor: Robert G. Taub
Institution: Children's Memorial and Columbus Hospital, Chicago
Description: This exhibit pictures and describes the common inflammatory conditions of the eye. Treatment is discussed with reference to the advantages and disadvantages of using a suspension ointment or solution. In particular, the clinical efficacy and safety of a new, more soluble corticosteroid-antibiotic solution is assessed. Tonometric readings were made where possible. Generally, results were excellent.

S-6

- Title:** **The Womanly Art of Breast Feeding**
Exhibitors: Drs. Ratner, Mendelsohn and White
Institution: LaLeche League International, Franklin Park
Description: This is an exhibit prepared by a committee for LaLeche League International through consultations with its members and medical advisory board. Information on breast feeding has been gathered over a thirteen year period through communication with mothers throughout the world and through constant consultations with our Medical Advisors who have taken a special interest in this subject. We found many reasons why women who wanted to breast feed were failing. Many other medical and non-medical facts came to light on this subject during the course of time LaLeche League has existed. This exhibit illustrates these findings and explains the functioning of the League.

S-7

- Title:** **Acid-Base Evaluation by a New Slide Rule**
Exhibitors: C. C. Rattenborg, Sanford Cobb, A. A. El Etr, M. R. Salen, H. J. Lowe and D. A. Holaday
Institution: University of Chicago, Pritzker School of Medicine, Chicago
Description: The exhibit, with a large scale working model of a new acid-base slide rule, demonstrates the evaluation of respiratory and metabolic changes. It discusses the terminology, the development of pathologic conditions, and their treatment. A folder with photographic reproductions is

handed out at the exhibit. A treatise and an actual slide rule is sent through the mail to the visitors who request them.

S-8

- Title:** Extended Care Programs on the Community Level
- Exhibitors:** Marshall A. Falk and Herman Weiss
- Institutions:** Fox River Rehabilitation Center and Louis A. Weiss Mem. Hosp., Chicago
- Description:** A 74-bed non-proprietary extended care facility, located in close proximity to several general hospitals, shows its experience over 3½ years, involving 1,821 patients. The exhibit first shows what an extended care facility is, how it differs from a nursing home and custodial institutions. Next, the goals of an extended care facility are outlined. The 3½ year study shows that 90% were referred directly from hospitals and the average length of stay in the facility was 29 days. Out of the total number of patients admitted the representative diagnoses are listed, and it was found that 8% were transferred to a general hospital; 12% were transferred to a nursing home; 80% were able to return to community life and 1% expired. The readmission rate and the age of patients are also outlined. The conclusions reached, show, through statistical analysis, the rate of the extended care facility in the community and how it may be used for Medicare and other patients to alleviate bed shortages in acute general hospitals; give better total medical care to the community, and provide the intermediate care for patients not incapacitated enough to require the facilities of the acute general hospital and return the patient to his maximum functioning ability in the community. The role of the private physician in relation to extended care facilities is outlined.

S-9

- Title:** Oral Contraception: A Public Health Viewpoint
- Exhibitor:** Morton B. Andelman
- Institution:** The Family Planning Clinics of Chicago
- Description:** The Family Planning Clinics of Chicago provide family planning guidance for 18,000 patients. Widespread acceptance of oral contraception elsewhere prompted this study which considers the feasibility of oral contraception among undereducated and underprivileged groups. Study results and especial considerations are presented in detail.

S-10

- Title:** Surgical Correction of the Cicatricial Alopecias
- Exhibitor:** D. Bluford Stough
- Institution:** . . . Hot Springs, Arkansas
- Description:** This exhibit shows the effectiveness of the

"Hair Transplantation" procedure, through the display of color transparent photos of outstanding cases over the past 7 years. These photos show the results of patients, before and after undergoing this technique, on such conditions as traumatic lesions of the scalp, Cicatricial Alopecia due to disease, and such rare conditions as congenital absence of eyebrows and permanent forms of Alopecia Areata. A complimentary article, in association with the present exhibit, entitled "Punch Scalp Autografts for Bald Spots" was published in the *Plastic and Reconstructive Surgery Journal*, November 1968, and will be available at the meeting.

S-11

- Title:** BCG in Tuberculosis Prevention
- Exhibitors:** Sol Roy Rosenthal and Philip G. Rettig
- Institutions:** Institution for Tuberculosis Research at the Univ. of Ill.; Cook Co. Hosp.; Chicago Board of Health and Research Foundation, Chicago
- Description:** Exhibit depicts leveling off of predicted decline in new cases of tuberculosis and demonstrates need for re-emphasis on tuberculosis. Methods for active prevention of tuberculosis to break the chain of infection are depicted, including reports of studies showing effectiveness of BCG vaccination in various age groups.

S-12

- Title:** The Professional and Cancer
- Exhibitor:** Steven G. Economou
- Institution:** American Cancer Society, Ill. Div., Inc., Chicago
- Description:** The latest Professional Education literature and films on cancer prevention, early detection and treatment will be available. Patient education material will also be available at no charge. The exhibit will consist of posters, films, brochures, pamphlets and monographs, flyers, charts and models. The subject area will specifically relate the following cancer sites: lung, cervix, breast, colon and rectum, oral and skin. The topic of smoking and health will also be covered.

S-13

- Title:** Atrial Septal Defect, Recognition and Treatment
- Exhibitors:** A. J. Pois, John Morledge, Gordon Tuffi, Peter Rank, Carl Schmidt
- Institution:** Jackson Clinic—Methodist Hospital, Madison, Wisc.
- Description:** This exhibit will feature the clinical diagnosis and management of interatrial septal defect, with special emphasis on the lesion in the adolescent and adult patient. The incidence, prognosis, and physical findings of atrial septal defect will be presented, as well as the characteristic x-ray and electrocardiographic features of the dis-

ease. Characteristic auscultatory findings will be presented by means of instructional heart sound recordings, and the diagnostic and prognostic value of cardiac catheterization will be shown. Surgical correction of atrial septal defect will be reviewed, with emphasis on modern cardiopulmonary bypass techniques. Visual aids will include illuminated reproductions of ECG's, chest x-rays, and diagnostic cardiac laboratory and surgical procedures.

S-14

Title: Dysfunctional Uterine Bleeding
Exhibitor: Richard E. Sand
Institution: . . . Encino, California
Description: This exhibit defines a practical approach to a full diagnostic evaluation pre-treatment of dysfunctional uterine bleeding in menstruating women. The question whether women with dysfunctional uterine bleeding should have a diagnostic D&C is discussed. The results of therapy of 60 cases of proven dysfunctional uterine bleeding treated with norethindrone-mestranol is presented.

S-15

Title: Fertility After Injectable Contraception
Exhibitors: Merrill W. Huffman, Stanley E. Smith, Jr. and J. Roger Powell, Jr.
Institution: Carle Clinic and Carle Foundation Hospital, Urbana
Description: This exhibit presents data accumulated from two year's experience using medroxyprogesterone acetate as a contraceptive agent. Patients received 150 mgms. of medication i.m. every three months. The return of fertility after long term therapy is confirmed by endometrial biopsy or by conception. The time span from last therapy to return of ovulatory cycles is presented. Endometrial biopsies were ob-

tained by plastic tube aspiration of the endometrium. This unique method of obtaining endometrial tissue is also presented.

S-16

Title: Patterns of Disease from the Pathologists Laboratory
Exhibitors: Coye C. Mason, S. Steven Barron and Herndon G. Shepherd
Institutions: Mason-Barron Pathology Laboratories, Chicago; Grant Hospital Laboratory, Chicago
Description: This exhibit illustrates how the laboratory can aid the physician in the establishment of an early diagnosis by means of newer technics in automated chemical analyses and molecular biology.

S-17

Title: Prevention of Edema in Surgery of the Hand
Exhibitors: Joseph L. Posch, Kim K. Lie, and Robert D. Lawson
Institution: Dept. of Surgery, Grace Hospital, Detroit, Mich.
Description: It is our feeling that the oral proteolytic enzyme is a useful adjunct to other means such as pre-surgical technics, compress dressings, elevation of hand, avoidance of post mobilization, and graded exercises during convalescence to reduce or prevent edema following surgery of the hand.

S-18

Title: Freeze-Etch, Electro Micrography
Exhibitor: H. Friederici
Institution: Department of Pathology, University of Illinois, Chicago
Description: Display of large size photographs demonstrating three dimensional electromicrography of frozen specimens. This technique permits the study at high resolution of cell surfaces of substances easily removed during conventional processing.

S-19

Title: Family Physician Treats The Psychiatric Patient
Exhibitors: Seymour Diamond & Bernard Baltes
Institution: Samuel H. Flamm Foundation
Title: The purpose of this exhibit is to bring to the attention of the doctors key symptoms of specific psychiatric disorders, and aid to differential diagnosis while stressing the need for careful history taking and examination of the patient. Adequate therapy and avoidance of drug abuse is stressed. The keys to psychiatric referrals are also presented.

Visit the Exhibits. Attend the Scientific Motion Pictures Program. The various symposia and sections will be educationally most worthwhile.

Technical Exhibits

Booths T 1-2-3 DANIELS SURGICAL & SUPPLY CO.

DANIELS—with Mid-America's Ultra Modern Facilities to serve your Modern Professional Needs will again feature the newest in "top line brand" equipment and supplies.

"Model Office Displays"—Consult with our Planning, Decorating, Financing and Service Department. See The NEWEST 1969 Office Furniture; HAMILTON'S NEW STEELCREST EXAMINING SUITE (A New Dimension in Quality Craftmanship and Patient Comfort). RITTER'S Hydraulic Tables, Autoclave, Office Coagulator, L/F Uniflex Diathermy and Bovie Units; UNITEST Blood Chemistry Unit; DANIELS Finger Tip Adjustment Stools; DANCHI Electronic Stethoscope and Cassette Tape Recorders; WELCH ALLYN Electrically Illuminated Diagnostic Instruments; BURDICK EK IV EKG and New Utility Waste Receptacles in Seamless High-density Polyethylene; NEW Vacuum Cast Cutter. NEW Colorful Reception Room Magazine Racks and Exam Room Patient Record Holders. The NEWEST in Acrylic Plastic Signs for Indoor and Outdoor Use. Also See our Booth Section devoted to the NEWEST in Disposable Products.

Descriptive Literature is Available on ALL Displayed Items.

Booth T-4 USV PHARMACEUTICAL CORPORATION

USV Pharmaceutical has recently introduced a number of new and interesting products and our local representative would welcome the opportunity to discuss them with you at our booth during the convention. Won't you please take a few moments and drop by to say hello?

Booth T-5 J. B. ROERIG DIVISION, Chas. Pfizer & Co., Inc.

We will display Roerig prescription drugs.

Booth T-6 KINGSLEY-QUINN, LTD.

Kingsley-Quinn, Ltd., Management Consultants, Medical Division offering a consulting service to the Medical Community in the areas of Physician Recruitment, Medical Clinic Organization and Administration, Public Relations, Medical Education and Communication.

Booth T-7 CHEK ✓ LAB, INC.

PROFICIENCY TESTING PROGRAMS FOR PHYSICIANS AND CLINICAL LABORATORIES.

Test specimens are provided periodically for the evaluation of technical procedures. Check ✓ Lab, Inc. has developed a new survey for the physician in private practice which is custom-designed for the office laboratory.

Results are included in a report which indicates standard deviations and individual results (by code number) as compared with the results of other participants and reference laboratories. Mr. Phillip W. Sears, Director of Special Services, will be in attendance.

Booth T-8 ILLINOIS MEDICAL ASSISTANTS ASSOCIATION

Booth T-9 PAUL H. ROBINSON, JR., INC.

The booth will be set up to answer questions regarding the Society's Retirement Programs.

Booth T-13 JOSEPH K. DENNIS COMPANY, INC.

The Joseph K. Dennis Company, Inc., Administrators of the Medical Profession's Group Insurance Programs, will be in attendance for the purpose of counselling with the members regarding insurance matters. Use this opportunity to review your present Insurance Portfolio and present any questions you may have concerning your present coverage.

PROGRAMS OF INSURANCE AVAILABLE
DISABILITY INCOME PROTECTION
WORLDWIDE ACCIDENTAL DEATH AND
DISMEMBERMENT
MAJOR HOSPITAL
BUSINESS OVERHEAD EXPENSE
GROUP LIFE INSURANCE
IN-HOSPITAL INDEMNITY PROGRAM

Booth T-14 PROGRAMMED LEARNING, INC.

Engaged in one of the nation's most dynamic industries—Programmed Education. The firm makes available to professional men as well as to students on all levels—the most dramatic technological advance in the remedial and developmental reading field—the automated speed reading pacer.

Booth T-15 GOVERNOR'S COMMISSION ON EMPLOYMENT OF THE HANDICAPPED

Booth T-17
COMPREHENSIVE PLANNING—
PARTNERSHIP FOR HEALTH
PUBLIC LAW 89-749
PUBLIC LAW 90-174

Committee on Legislative Information,
 Chicago Medical Society

J. Ernest Breed, M.D., Chairman

Exhibit consists of: 1. Umbrella (large, outdoor, colorful type); suspended under umbrella are factors covered by the law. 2. Diagrams on wall showing chain of organization and command with areas specified wherein physicians should take part. 3. Automatic slide projector with 20 slides describing salient features of the law. 4. Stand-up display panels with questions and answers. Hand out literature on law.

Booth T-20
FINANCIAL CONCEPTS, INC.

Financial Concepts, Inc. is a unique corporation specializing in individually tailored investment programs, tax shelters, personal financial management and practice management for physicians, dentists, and other high income professionals. FCI provides a wide range of expert services with offices in Los Angeles, San Francisco and Chicago.

Booth T-21
AUDIO-DIGEST FOUNDATION

Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association) gives the busy physician a time-saving tour through the best of some 600 current medical journals, plus the highlights of scores of national meetings. Time-proven, but still unique—these medical tape-recorded services are now offered in reel to reel tape and Phillips type cartridges—General Practice, Surgery, Internal Medicine, Obstetrics & Gynecology, Anesthesiology, Ophthalmology and Pediatrics.

Digest subscribers listen in their car, home or office. Carefully selected tape equipment for playing the Digests is offered at the convention by Pacific Medical Equipment Co.

Booth T-22
APACHE CORPORATION

The function of Apache Corporation, through its subsidiary Apache Oil Programs, Inc., is to organize, offer and manage drilling programs for individuals and corporations whose taxable incomes render attractive and justify the inherent risk of oil participation.

Booth T-23
PFIZER LABORATORIES

The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information.

To make your visit worthwhile, technically trained Medical Service Representatives will be on hand to discuss with you the latest developments in Pfizer research.

Booth T-24
FLINT LABORATORIES

Featured will be FLINT Laboratories' newly introduced CHOLOXIN® (sodium dextrothyroxine) which effectively lowers elevated serum cholesterol. Also featured will be HU-TET® (tetanus immune globulin, human), the homologous tetanus antitoxin, and SYNTHROID® (sodium Levothyroxine) indicated in hypothyroidism.

Booth T-25
SANDOZ PHARMACEUTICALS

Sandoz Pharmaceuticals cordially invites you to visit our display at booth 25, where we are featuring Mel-laril, Sansert, Cafergot P-B, Fiorinal and Fiorinal with codeine.

Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

Booth T-26
MEDICAL BUSINESS CONSULTANTS

Professional Corporations
 Personal Tax Planning
 Personal Financial Planning
 Partnership Planning
 Practical Tax Savings

Booth T-28
PEPSI-COLA GENERAL BOTTLERS, INC.

Booth T-29
MEDCO PRODUCTS, CO., INC.

Presenting the new MEDCO-SONLATOR TWIN, a new concept in therapy. Combining the first significant advance in Ultrasound therapy, selective rate pulsed Ultrasound, synchronized with Muscle Stimulation, and simultaneously applied through a single 3-way sound applicator. A few minutes spent in our booth should prove of value to your practice.

Booth T-30
INTERNATIONAL PHARMACEUTICAL CORP.

GLY-OXIDE® Liquid—cleansing, antimicrobial oral solution to relieve pain, cleanse, debride and protect against secondary infection.
 DEBROX® Drops—to save time and avoid excess instrumentation in ear wax removal.
 DIA-QUEL Liquid—new, pleasant tasting antidiarrheal.

Booth T-31
COCA-COLA USA

Ice Cold Coca-Cola service through the courtesy and cooperation of the Coca-Cola Bottling Company of Chicago and Coca-Cola USA.

Booth T-32
WINTHROP LABORATORIES

Winthrop Laboratories cordially invites you to visit Booth 32 where the following products will be displayed:

Talwin®—brand of Pentazocine (as lactate)
NegGram®—(brand of nalidixic acid)
Isuprel® (brand of isoproterenol) Mistometer

Booth T-33
TUFTS-EDGCUMBE, INC.

We will have personnel available at our booth with literature on the complete line of Piper airplanes. For today's on-the-go generation, Piper airplanes combine speed and flying ease with sparkling good looks. Stop by the booth for literature of the pace-setting Piper line.

Booth T-35
BRISTOL LABORATORIES

Bristol Laboratories' exhibit features POLYCILLIN (ampicillin trihydrate). This member of the Bristol family of synthetic penicillins is the first oral penicillin bactericidal against a significant number of Gram-negative and full spectrum of penicillin G-sensitive Gram-positive pathogens.

Booth T-36
UNITED MEDICAL LABORATORIES, INC.

Thoughtfully selected profile studies yield information not obtainable from history and physical examination alone. Repeated tests establish a normal chemical and metabolic profile for a given individual. Noting early changes in the patient's laboratory pattern, as compared to their normal base line, helps to detect disease before serious physical changes have occurred.

Booth T-38
SMITH, KLINE & FRENCH
LABORATORIES

Featured will be our diuretic adjuvant 'Dyrenium' (triamterene, SK&F) and our comprehensive diuretic, 'Dyazide'. Each 'Dyazide' capsule contains 50 mg. of 'Dyrenium' (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

Booth T-39
SOCIAL SECURITY ADMINISTRATION
HEALTH INSURANCE

Booth T-40
E. R. SQUIBB & SONS

Members of the medical profession who search for better agents to prevent and treat disease are eager to learn of new products and improvement in products.

Since therapeutic advances are constantly being introduced to the professional market, much valuable product information is available. Your inquiries about the latest results of our research will be welcomed.

Booth T-41
MERCK, SHARP & DOHME

The Merck Sharp & Dohme exhibit has been designed to supplement the physician's therapeutic armamentarium. Technically trained personnel are present to discuss the scope and variety of services offered.

Booth T-42
THE UPJOHN COMPANY

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. They are here to discuss products of Upjohn research designed to assist you in the practice of your profession. They welcome your inquiries and comments.

Booth T-43
MEAD JOHNSON LABORATORIES

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about Vasodilan, Enfamil, and Oracon.

Booth T-44
PARKER, ALESHIRE & CO.

As the administrators of the officially sponsored Group Insurance Programs for members of the Illinois State Medical Society, we invite you to stop at our booth and discuss these fine programs with our representatives.

We have been privileged to administer your Group Disability Plan since 1947, and your Group Major Medical Plan since 1958. A Malpractice Plan was approved in 1968.

The protection available is unexcelled, another benefit of your membership in the ISMS, and deserves your consideration.

Booth T-45
FLINT DIAGNOSTICS

New systems for blood serum analyses are now being marketed by FLINT DIAGNOSTICS. Utilizing special photoelectric scanning and advance fiber optics, these devices provide sophisticated tests rapidly and easily. Designed for use in the physician's office, they combine compact size, modern styling plus improved procedures. See the exciting new developments and the clear techniques now possible in demonstrations at the FLINT DIAGNOSTICS Booth 45.

Booth T-46
PM-ILLINOIS, INC.

For over 36 years the PM GROUP has provided a complete business service for the medical profession. The trademark PM is the brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc., of Battle Creek, Mich. It assures PM clients that the knowledge, experience and integrity of the oldest and largest such firm in the country are at their command.

You are cordially invited to stop and meet the experienced PM executives there.

Booth T-47
PARKE, DAVIS & CO.

Medical service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Booth T-48
ELI LILLY & CO.

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance will welcome your questions about Lilly pharmaceutical products. You may be particularly interested in discussing LORIDINE® Cephaloridine.

Booth T-49
SIEMENS MEDICAL OF AMERICA, INC.

SIEMENS MEDICAL will display many advancements in diagnostic and therapy equipment. Our representatives will be on hand to demonstrate our equipment and discuss practical applications with you. We believe a few minutes at our booth will prove to be well spent.

Booth T-50
G. D. SEARLE & CO.

You are cordially invited to visit the SEARLE booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be information on Ovulen-21, Enovid, Aldactazide, Flagyl, Lomotil, Pro-Banthine and other drugs of interest.

Booth T-51
LEDERLE LABORATORIES

Lederle Laboratories is pleased to support the 129th Annual Convention of the Illinois State Medical Society by its presence at this meeting. Our trained representatives in Booth 51 will be glad to discuss our well-known brand-name drugs such as DECLOMYCIN® and ACHROMYCIN®, the world's foremost broad-spectrum antibiotics; ARISTOCORT®, the widely known steroid; the trivalent poliovirus vaccine ORIMUNE®; and our other products applicable to your practice. Information is also available on our many other services to medicine.

Booth T-52
ABBOTT LABORATORIES

The ABBOTT display features the antihypertensive drug Enduronyl® (methyclothiazide and deserpidine). The deserpidine component offers a reduced incidence of rauwolfia side effects, compared to reserpine. Also Normosol® solutions, modern successors to normal saline and dextrose solutions, providing physiologic concentration of the principal ions of normal plasma.

Booth T-53
MILLER PHARMACAL CO.

Magnesium in a complex form designed to support the extra requirements of the body's hundreds of enzyme systems for minerals, vitamins and amino acids during periods of stress and subnormal nutrition. Patients and physicians appreciate these products as an aid in—ALCOHOLISM! ARTHRITIS! DIABETES! HEART DISEASE! MULTIPLE SCLEROSIS! OSTEOPOROSIS & PREGNANCIES!

Booth T-54
ARNAR-STONE LABORATORIES, INC.

AMERICAINE TOPICAL ANESTHETIC—20% dissolved benzocaine in a water-soluble base—ointment, suppositories and aerosol forms.

HAZEL-BALM—cooling, soothing witch hazel and emollient lanolin in aerosol form—provides a comforting "cushion of foam."

ISOCOLOR—oral nasal decongestant and bronchodilator—tablet, liquid and timesule forms, also the anti-tussive Isoclor expectorant.

SOPOR—Non-barbituate hypnotic sedative for gentle untroubled sleep. Particularly useful with geriatric patients.

Booth T-55
ENCYCLOPAEDIA BRITANNICA, INC.

Encyclopaedia Britannica welcomes delegates to the Illinois State Medical Society Convention. As part of the EB's 200th Anniversary, we have on display the great new edition of Britannica, Great Books of the Western World, the Replica Perspective, etc.

Stop and inspect these products in Booth 55. They are available to the delegates at our convention offer.

Booth T-56
THE MEDICAL PROTECTIVE CO.

With exceptional proficiency in defense, so essential to the Doctor's protection today, The Medical Protective Company offers unexcelled coverage in any claim for damages based on professional services rendered or which should have been rendered. Its experience from the successful handling of over 97,000 claims during 70 years of Professional Protection Exclusively is unparalleled in the professional liability field.

Booth T-57
CIBA PHARMACEUTICAL CO.

Booth T-58
W. B. SAUNDERS CO.

Saunders will be displaying their full line of clinical books. They comprise, without a doubt, some of the most useful modern tools a busy practitioner can use to make himself more effective.

Booth T-59
ASTRA PHARMACEUTICAL PRODUCTS,
INC.

Information and descriptive literature pertaining to Xylocaine® (lidocaine) and Citanest® (prilocaine) local and topical anesthetics, and iron preparations As-trafer® (dextriferron for intravenous use and Jecto-fer® (iron sorbitex) for intramuscular administration will be available at the Astra booth.

Booth T-60
CONTOUR CHAIRS CO.

Booth T-61
ARMOUR PHARMACEUTICAL CO.

You are cordially invited to visit the Armour Pharmaceutical Company Booth. The latest product information and clinical studies for Chymoral-100 Tablets and Letter Tablets (Sodium Levothyroxine, Armour) will be featured.

Booth T-62-63
BLUE SHIELD PLAN,
ILLINOIS MEDICAL SERVICE

Doctor—

Learn how to MAKE THE MOST OF YOUR EARNINGS

Attend the

Workshop on Financial Planning

A 1969 Convention "Special" brought to you by the ISMS Committee on Medical Economics in co-operation with The Society of Professional Business Consultants

LEARN HOW TO:

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Never before has a program of this type been so important to the security and growth of your estate. Because you, as a physician, do not enjoy fringe benefits offered most salaried employees, you must learn to develop a surplus from your own earnings. The **Workshop on Financial Planning** tells you how . . . in a comprehensive, three-hour program of practical, how-to-do-it presentations from top professional business consultants.

PRE-REGISTRATION FORM

Please make (no.) reservations for me at the **Workshop on Financial Planning**, to be held in conjunction with the Illinois State Medical Society Annual Convention in the Sherman House Hotel, Chicago.

Name

Address
(number) (street)

.....
(city) (state) (zip)

Please detach this form and return to:

Public Relations Division
Illinois State Medical Society
360 North Michigan Avenue
Chicago, Illinois 60601

Scientific Motion Picture Schedule

Gold Coast Room III

Note: On Monday, May 19, the film program will start at 2:00 p.m. On Tuesday and Wednesday, the program will start at 9:00 a.m.

Morning Program

9:00 to 9:23 a.m.	Renal Hypertension/Bilateral Nephrectomy/Kidney Transplantation
9:28 to 9:37 a.m.	Intrauterine Fetal Transfusion
9:42 to 10:02 a.m.	Stroke—Early Restorative Methods in Your Hospital
10:07 to 10:44 a.m.	Clinical Entities, Coronary Occlusion
10:49 to 11:19 a.m.	Thyroid Deficiency—Current Concepts of Diagnosis and Treatment
11:24 to 11:41 a.m.	Shock: Recognition and Management

Afternoon Program

2:00 to 2:20 p.m.	The Patient Is A Person
2:25 to 2:49 p.m.	Cine Angiographic Diagnosis Of Coronary Artery Disease, Part I, Medical Aspects
2:54 to 3:14 p.m.	Myocardial Revascularization—Vineberg Implant
3:19 to 3:41 p.m.	The Measurement Of Depression
3:46 to 4:30 p.m.	Essentials Of The Examination And Evaluation Of The Patient With Vertigo

Special Film Showing

The "Transplanters," an absorbing 41 minute color motion picture that focuses on the moral as well as the medical aspects of transplant surgery will be shown at 2:00 and 2:45 p.m., Wednesday, May 21, in the Louis XVI Room.

The film portrays with unusual candor the personal and sometimes divergent views of seventeen of the world's most distinguished surgeons and specialists, including Barnard, Cooley, DeBakey, Shumway, Kantrowitz, Merrill, Harken.

Produced in a manner unique to medical films, The "Transplanters" is a moving and perceptive documentary on one of the most dramatic achievements of modern medicine. It is presented as a service to the profession by Johnson and Johnson and its affiliated companies in the medical field.

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Chicago, Illinois 60601

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and departure on _____

DAY

DATE

TIME

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<input type="checkbox"/> \$12.00-\$14.00	<input type="checkbox"/> \$16.00-\$18.00	<input type="checkbox"/> \$18.00-\$20.00	ALCOVE (Sitting Room - Bed Room Combination) <input type="checkbox"/> \$29.00-\$31.00
<input type="checkbox"/> \$15.00-\$17.00	<input type="checkbox"/> \$19.00-\$21.00	<input type="checkbox"/> \$21.00-\$23.00	SUITE (Parlor & 1 Bed Room) <input type="checkbox"/> \$35.00 <input type="checkbox"/> \$45.00 <input type="checkbox"/> \$50.00
<input type="checkbox"/> \$18.00-\$21.00	<input type="checkbox"/> \$22.00-\$25.00	<input type="checkbox"/> \$24.00-\$27.00	<input type="checkbox"/> \$70.00
IF WE ARE NOT ABLE TO RESERVE A ROOM AT RATE REQUESTED A ROOM AT THE NEXT AVAILABLE RATE WILL BE RESERVED. ALL ROOMS SUBJECT TO 4.1% ILLINOIS HOTEL OPERATORS OCCUP. TAX.			SUITE (Parlor & 2 Bed Rooms) <input type="checkbox"/> \$80.00 <input type="checkbox"/> \$90.00 <input type="checkbox"/> \$100.00
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DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:
Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.

(Warning: May be habit forming)

To reduce hypermotility and frequency.

Homatropine Methylbromide... 0.15 mg.

A safe dose for mild spasmodic to curb cramping and griping.

Pectin... 24. mg.

Demulcent, adsorbent. Helps form stools.

Alcohol 10% by volume.

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's rule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

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Meeting Memos

April 20-25—American College of Physicians

50th Annual Session

Conrad Hilton Hotel, Chicago

April 20-26—International College of Surgeons

1st Intl. Symposium on Obstetrics & Gynecology
Chicago

April 21-24—Industrial Medical Association

American Industrial Health Conference
Shamrock Hilton Hotel, Houston, Texas

April 24-25—Plastic Research Council

14th Annual Meeting

Thorne Hall, Northwestern University Medical School Campus, Chicago

April 24-26—American Academy of Physical Medicine and Rehabilitation

Sheraton Chicago Hotel, Chicago

April 24-26—American College of Chest Physicians & University of Illinois College of Medicine

Pulmonary Care In Children
University of Illinois Medical Campus
828 Wolcott Ave., Chicago

April 28-29—American Medical Association

Sixth Congress on Environmental Health
"Noise Pollution"
Drake Hotel, Chicago

April 28-30—American Diabetes Association

First Paramedical Postgraduate Course in Diabetes
Boston, Mass.

April 29-May 1—Illinois Institute of Technology Research Institute

2nd Scanning Electron Microscope Symposium
IIT Campus, 10 W. 35th St., Chicago

May 1-2—Illinois Heart Association

Annual Scientific Meeting
"Cures And Crutches For Crippled Children"
Pere Marquette Hotel, 501 Main St., Peoria

May 1-3—Illinois Society of Anesthesiologists

6th Midwest Anesthesiology Conference
"Anesthesia And The Autonomic Nervous System"
Conrad Hilton Hotel, Chicago

May 1-3—University of Florida College of Medicine & Mound Park Hospital Foundation, Inc.

Symposium on Anxiety & Depression
"Modern Interpretations"
Tides Hotel, Redington, Fla.

May 5-9—Medical Library Association, Inc.

3rd Intl. Congress on Medical Librarianship
Amsterdam, The Netherlands

May 6—St. Mary of Nazareth Hospital

General Medicine Lecture Series Program
"Serum Enzymes-Diagnostic Significance"
1120 N. Leavitt St., Chicago

May 8—University of Illinois Alumni Association

Address By Adlai E. Stevenson III
"Conducting The People's Business"
Louis XVI Room, Sherman House, Chicago

May 8-10—American Association for the History of Medicine

Baltimore, Md.

May 8-10—American Cancer Society

National Conference on Breast Cancer
Shoreham Hotel, Washington, D.C.

May 8-10—University of Cincinnati—Dept. of Pediatrics

Postgraduate Course in Pediatrics
The Children's Hospital, Cincinnati, Ohio

May 13—St. Mary of Nazareth Hospital

General Medicine Lecture Series Program
"Pancreatitis—Acute & Chronic"
1120 N. Leavitt St., Chicago

May 14-16—National Society For The Prevention of Blindness

Annual Conference
Pfister Hotel, Milwaukee, Wis.

May 18-21—ILLINOIS STATE MEDICAL SOCIETY

Annual Meeting
"Medicine In The Seventies"
Sherman House, Chicago

May 19-23—National League For Nursing

Annual Convention
Cobo Hall, Detroit, Mich.

(Continued on page 528)

a broad-spectrum antibiotic for the diabetic:

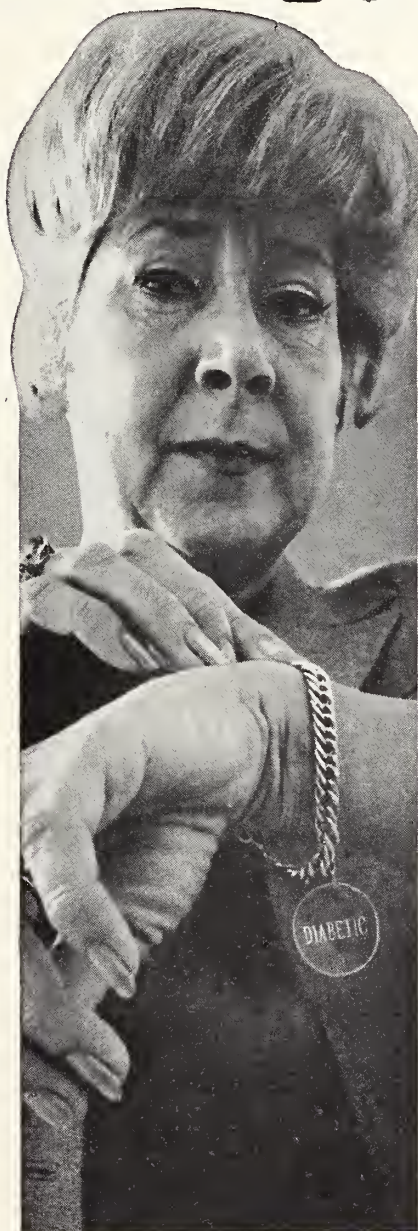
threat or therapy?

Disordered metabolism makes her prone to bacterial infection—and to moniliasis.

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Each capsule contains 250 mg. of tetracycline phosphate complex to control sensitive bacterial pathogens...and nystatin, 250,000 units, as a precautionary measure against troublesome vaginitis, proctitis or other monilial infections. However, superinfection with other, non-susceptible organisms may occur.

Tetrex-F[®]
(tetracycline phosphate complex-nystatin)



PRESCRIBING INFORMATION: Tet-F, 5—2/23/67. For complete information consult Official Package Circular.

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Contraindications: The drug is contraindicated in patients hypersensitive to its components.

Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).

Precautions: Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.

Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.

Usual Adult Dosage: 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

Supplied: Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

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Accidents and Firearms

Although prevention programs in the firearm accidents field often emphasize the inherent hazard to hunters, statisticians point out that nearly 60 percent, or 1,500 of the 2,600 estimated firearm accident deaths in the United States in 1966 resulted from mishaps in and about the home. These fatal home accidents occurred at the rate of 7.6 per million persons. To a considerable extent they were the result of servicing or playing with a firearm, and were largely self-inflicted. The weapon most often involved was a long gun, that is, a shotgun or rifle.

Every age group contributed to the toll. Eleven percent of those fatally injured were under age 10. Most frequently, the weapon was accidentally discharged while in the hands of the victim or another youngster, often a brother. Nearly two fifths of the victims were 10-24 years old; most of these were in their teens. Approximately one fifth of the fatalities occurred in each of the older age groups, 25-44 and

45-64. Four fifths of the total number killed were males.

At least 29—or one fifth—of the 143 fatal accidents occurred during the cleaning, oiling or repairing of the firearms.

While 83 victims died of self-inflicted wounds, another 24 were shot by family members. Ten victims were shot by a brother, seven wives by their husbands, and the remainder by wives (2), sons (2), fathers (2) and uncle (1).

Statisticians point out that firearms accidents often involve body areas containing vital organs, so that the victim has little chance of survival. In this insurance study, 59 of the 127 fatalities about which information was available involved the head, most often reported as a brain or skull injury. An additional 44 of the accidents caused injuries to the chest area, particularly the heart and lungs. The abdomen was the site of most of the remaining injuries.

Regarding Addict Treatment

Apparently like Dr. Pierce James (*The Lancet*, pg. 1239, Dec. 7, 1968), I resent that I should have to pay an extra four shillings on my already over-taxed bottle of whisky to pay for free heroin to heroin addicts. However, I almost equally resent Dr. Field's ungracious attack on psychiatrists (*The Lancet*, pg. 1350, Dec. 21, 1968). Far from undertaking the burden of running "addiction units" out of "lack of humility," we agreed to this with the utmost reluctance, and largely because we were told that failure to do so would be socially irresponsible, since there was an imminent danger of a Chicago-gangster-style black market developing if we did not. Many of us protested that that was a police responsibility. Many psychiatrists who feel obliged to take part in the scheme appreciate perfectly well that the idea of successfully "treating" our present addict population is wildly unrealistic, especially with the resources available. (F. P. Haldane, West Middlesex Hospital, Isleworth, Middlesex "Letters to the Editor," *The Lancet* [Jan. 4] 1969.)

Average Cost of Medical Society Dues

A physician in Oregon's Multnomah County (Portland) pays \$220 a year in professional membership dues if he belongs to the county, state, and national medical associations. This appears to be close to the national average, according to a recent survey. AMA dues are the same everywhere—\$70 a year. Multnomah County's annual dues of \$65 compare with those of other county societies that range from a low of \$35 in Chicago to a high of \$137 in Kansas City, Mo. Oregon Medical Association dues of \$85 are in the middle range of state dues, which vary from \$50 in Connecticut, Florida, Kansas, Louisiana, Ohio, and Texas to \$125 in Iowa. Professional affiliations appear to be more expensive in Des Moines, Iowa, among the areas surveyed, than anywhere else in the country—with the total tab there amounting to \$320. ("Doctor's Business." *Medical World News*. [Feb. 21] 1969, pg. 47)

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 - ☐ Aids in rehabilitation of the constipated patient by facilitating regular elimination
 - ☐ No laxative tolerance or rebound constipation reported in clinical experience
 - ☐ Even many previously intractable cases have been successfully treated with SENOKOT preparations
 - ☐ Virtually free of side effects at proper, individualized dosage levels
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- Dosage:** (preferably at bedtime)—*Adults:* 2 tablets (max. 4 tablets b.i.d.). *Children:* (over 60 lb.) 1 tablet (max. 2 tablets b.i.d.). **Supplied:** Bottles of 50 and 100 tablets.

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Red Cross Tallies Blood Collection

During the fiscal year of 1967-68, the American Red Cross collected 3,008,400 units of blood—an increase of 29,300 over the previous year's collection.

Whole blood was distributed for patients in 4,300 hospitals in 48 states, the District of Columbia, Puerto Rico and the Virgin Islands; 2,500 of these hospitals received their total supply of blood from the American Red Cross.

In addition to whole blood, the following blood products were distributed:

Serum Albumin	89,400 units (100 ml. 25%)
Gamma Globulin	653,200 units (1 ml.)
Fibrinogen	4,400 units (2 g.)
Vaccinia Immune Globulin	1,900 units (5 ml.)
Packed Red Cells	147,700 units (275 ml.)
Fresh Frozen Plasma	59,500 units (225 ml.)
Platelet Rich Plasma	1,400 units (225 ml.)
Platelet Concentrate	20,500 units (25 ml.)
Cryoprecipitate	21,100 units (20 ml.)
Antihemophilic Factor	Concentrate 2,600 vials

The gross cost of all blood services by the national organization and chapters throughout the states was \$34,509,100.

Film Reviews

"A Staff, Not A Crutch" is the new title of a film just completed by the Illinois Association For The Mentally Retarded. This 20 minute color film grew out of the practical experience of the Wilmette Post Office in providing challenging job opportunities for graduates of the New Trier Township High School Special Education Program. Interested groups should contact the IAMR.

"The Trip Back" is the title of a new film concerned with drug addiction. The film, in which Florrie Fisher, 50, tells young people how she wasted 23 years of her life being a hustler, dope addict, thief and prostitute, is available in 16 mm., color, from the **New York Daily News**, Public Relations Dept., 220 E. 42nd St., New York, N.Y. 10017. No rental fee.

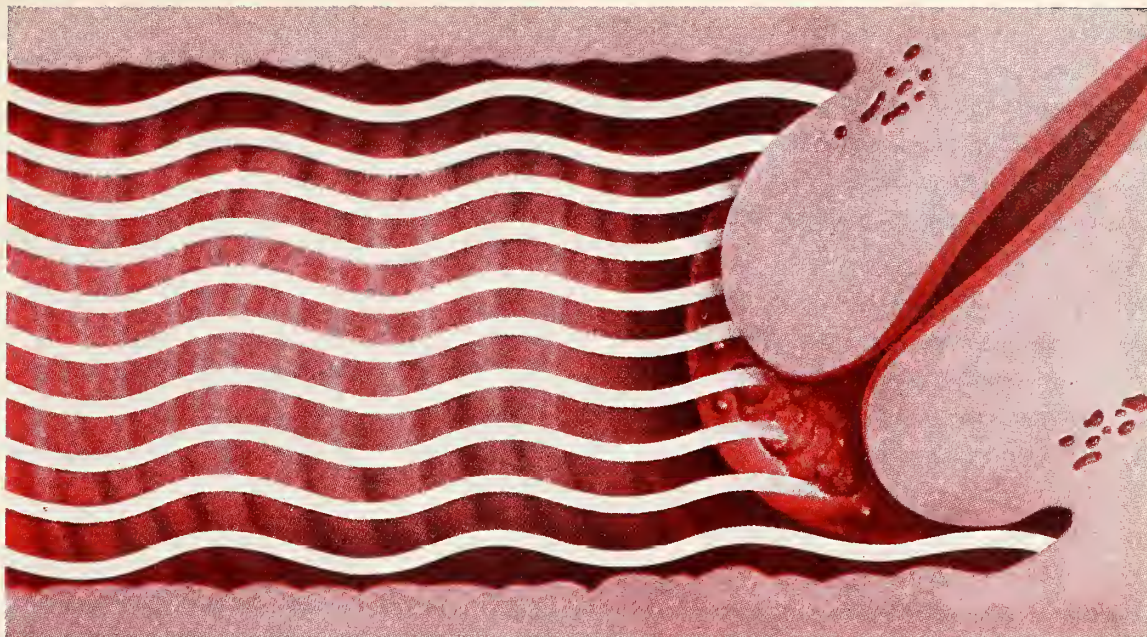
A new film entitled "Bridge To Somewhere" is now available free on loan to agencies and individuals concerned with services to the blind. Made to commemorate the 75th anniversary of the invention of the braille writer and stereotype machine by former Illinois Braille and Sight Saving School superintendent, Frank Haven Hall, this 30 minute, 16mm., color film features the educational and child care programs at the Illinois Braille and Sight Saving School. For further information contact: Film Library, Illinois Information Service, 107 State Office Building, Springfield, 62706.

The Need for Modernization

The need for modernization stands out as a key problem for at least half the nation's hospitals, according to a PHS report. Based on data furnished in the 1967 State Hill-Burton plans, the report indicates that a better balance of facilities is required to eliminate the problem of oversupply in some areas and undersupply in others.

State agency plans indicate that within 5 years because of conversions, mergers, and the phasing out of small facilities, there will be nearly 900 fewer nonfederal general hospitals than the 6,661 reported as of January 1, 1967. There is a need for modernization of nearly 3,300 general hospitals containing 263,000 beds and 4,850 long-term care facilities with 208,000 beds.

The PHS report points out that new construction will be required in some areas to accommodate increased demands for services. About 100 new general hospitals will be needed, primarily in suburban areas. (**Medical Staff-in-Action**. Published by the American Medical Association [Dec.] 1968, pg. 2.)



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reduce odor...reassures the patient

StomAseptine douching is a valuable adjunct to
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internal irrigations help maintain a clear field by
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the patient a refreshing, reassuring procedure
that can help speed the healing process.

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for April, 1969



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New Questions In Medical Morality

BY J. ERNEST BREED, M.D./CHICAGO

This paper was presented to the county association of clergymen and the staff of Perry Memorial Hospital, Princeton, on November 7, 1968.

Ladies and gentlemen, it is good indeed to see clergymen and doctors working together and I would congratulate you here in the Perry Memorial Hospital for your close association. In the old days when life was simple, members of our two professions were well acquainted and enjoyed lifelong associations. In the past few decades there has been somewhat of a separation of the two professions, but never really a divorce. It is good that the reunion is taking place now, since it is so significant to the patients' welfare.

I am going to discuss, under the title of "New Questions In Medical Morality," a whole series of problems that present innumerable questions of ethics. I have no answers, but these areas will require the combined thinking of not only our two professions, but the legal profession and of society as a whole.

Medical Ethics

When we speak of medical ethics the first thing that comes to mind is the Hippocratic Oath, then the ten sections of the AMA Code of Ethics, together with the 75 pages of elaborations by the AMA Judicial Council. These, of course, have mainly to do with the general behavior of physicians

toward their fellow practitioners, toward their patients, and toward society as a whole.

My discussion is not on the Principles of Medical Ethics, but about innumerable medical problems created by the rapid changes in the world at large and in the science of medicine. Rules and regulations as yet have not been formulated in some specific areas.

Medical ethics are not promulgated by doctors. Society itself lays down the rules by which we practice. The clergy serving as the keeper of the mores must have a big part in propounding the answers to the questions here presented. But neither the medical profession nor the clergy can dictate the ultimate solutions.

Let's look at some of the old problems made difficult by changing world conditions. As you are all aware the population, now some three and one-half billion souls, doubles every 30 years. Famine, war, and disease have kept the growth rate down in the past, but for the most part these limiting forces are under control. The death rate among infants, formerly so very high is now low, so that the young people live to grow up and reproduce.

Since people increase geometrically, that is 4, 8, 16, 32, etc., and the food supply increases arithmetically—1, 2, 3, 4, etc., it is obvious that at some time the population-food collision will occur. The U.S. Department of Agriculture estimates that in the year 1987 we will no longer be able to feed the 33 foreign nations we now supply and a new book called *Famine In 1975*, just published, maintains the collision will occur in 1975. It would seem that population increases must be controlled or starvation of millions will occur. This, then, is one of our problems. Do we kill off the old folks? Do we encourage birth control or abortion? Do we sterilize a large percent of our young; can we find some other solution? Or will we eventually let people starve? We in this room do not face this problem today, since in our lifetime all

(Continued on page 506)

J. Ernest Breed, M.D., is a Chicago radiologist. He is a graduate of Northwestern University Medical School and a member of numerous professional organizations including the American College of Radiology, the American Radium Society, and the Society of Nuclear Medicine. In addition, Dr. Breed is an ISMS trustee from the Third District.



**"coughing
is not a harmless
privilege"**

—Current Therapy 1967, ed. by Conn, H. F., P. 88—

**if cough
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INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

***DOSAGE:** *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours.
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Medical Morality

(Continued from page 504)

in our country can be fed, but eventually this will be one of the world's most pressing problems.

We desperately need a definition of "Death." When I started practice a patient was considered dead when his heart stopped beating or when he stopped breathing. Now we call the first cardiac arrest and this state often can be corrected. If the patient stops breathing we can put him on an artificial respirator and keep him going for a time. If a patient's kidneys stopped working in the old days he soon died of uremia. Now he may be put on a dialyzer or given a kidney transplant.

Two Kinds of Death

Dr. Frank J. Ayd has described two kinds of death; clinical death and biological death. Clinical death is that time when spontaneous respiration has ceased and the heart has stopped beating. Biological death is defined as death of the tissues. He asked several pertinent questions: should the doctor delay biological death after clinical death by keeping tissues alive with stimulants, respirators and other resuscitative devices? If he does, can he, at any time, discontinue the artificial means of preserving a semblance of life? When clinical death has occurred can a physician ask the family's permission to delay biological death long enough for the removal of an organ for transplantation to another whose life may be saved by spare part surgery? If such permission is obtained, when does the patient die? Before resuscitative measures, or after they are discontinued? When a patient with a cardiac pacemaker or an artificial heart is moribund and realistic hope of recovery is gone, is he murdered by the doctor that turns off the current? When is a person dead? This question not only concerns physicians, but philosophers, theologians, moralists, lawmakers, judges. In fact—everyone.

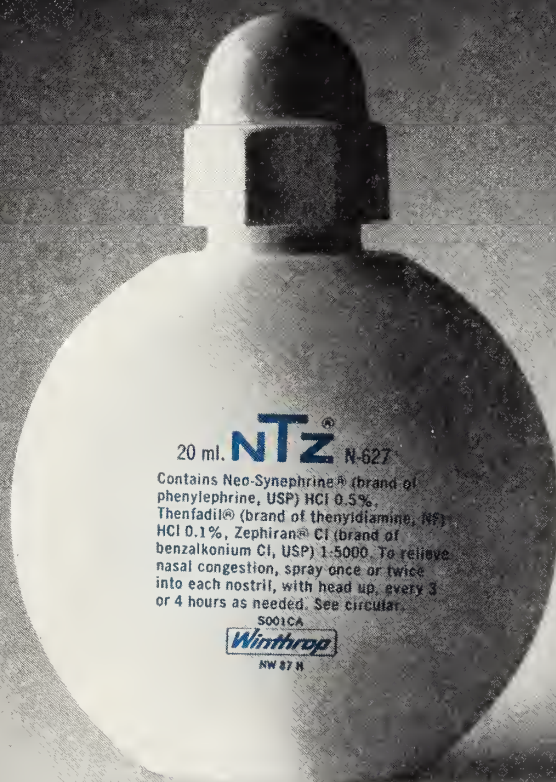
A legal definition of death states that a patient is dead when there is no chance of resuscitation and when the physician pronounces him dead. The dictionary defines death as the cessation of life. This is quite simple, but still it leaves us up in the air. The American Bar Association, meeting in Hawaii last spring, set up a committee to revise the legal definition of death. The

American Heart Association and the World Health Organization are working on the same problem. In general it may be stated that all groups are beginning to identify clinical death with a flat encephalographic tracing of from 5 to 20 minutes. However, it has been noted that with certain toxic poisoning, such as with the barbiturates, a brain wave may be flat for several hours and the patient still recover.

Going to the next question, whom do we resuscitate? About a year ago England's Minister of Health, Kenneth Robinson, established a principle that a hospital medical staff should be permitted to choose which patients it would allow to die and which it should try to resuscitate. The general hospital directive stated that resuscitation was not to be attempted in cases where the heart stopped beating in those over 65, those who suffered from malignant disease, chronic kidney disease, or chronic chest diseases. This measure was given considerable publicity and public criticism followed, especially since he instructed all decisions to be kept secret. Most of us would agree that it is useless to indefinitely prolong the life of a mass of inert and meaningless protoplasm by artificial means, but it would appear that Mr. Robinson's directive might include some that could be rehabilitated.

The next question is—when do you turn off the respirator? This assumes the patient to be clinically dead, that is, with no brain waves demonstrated on the electroencephalogram, but the patient's body is being kept alive by artificial respiration and by stimulants. Recently a Swedish physician kept an 80 year old woman alive for five weeks by intravenous therapy. Considering further treatment was futile and that it was inhuman to prolong her suffering, he discussed the problem with the relatives and with their permission he stopped the intravenous therapy and she died. The same physician also attended a 65 year old woman in a diabetic coma which appeared irreversible. He requested and was refused permission by her relatives to discontinue life saving therapy. Subsequently the patient's son wrote the authorities charging the doctor with trying to kill his mother. The doctor was charged and found guilty of neglecting medical standards by the
(Continued on page 508)

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The *first spray*—1 or 2 squirts—of NTz opens the inferior part of the common meatus. The *second spray*, a few minutes later, shrinks the turbinates to promote adequate sinus drainage and ventilation—to help prevent sinusitis. Dosage may be repeated every three or four hours.

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Medical Morality

(Continued from page 506)

Swedish Medical Board. The case later came to court. Fortunately the judge ruled the physician had acted properly in both cases.

A very good personal friend who is a prominent chest surgeon in Chicago had this problem to face with his own mother. After a severe stroke, following which she was unconscious for several weeks and was being kept alive on an artificial respirator, he himself turned off the respirator. When do you turn off the respirator? How long do you continue the life of tissues after clinical death?

Now that impending uremia can be relieved with a dialyzer many questions of moral ethics arise. The cost of keeping a person on a dialyzer varies from 5 to 20 thousand dollars a year. It is estimated that 35,000 new patients in the terminal stages of chronic renal failure present annually, of which about 28,000 are doomed. However, about 7,000 between the ages of 15 and 54 are suitable candidates for hemodialysis or renal transplantation. This year there are dialyzing facilities for about 550 of these new patients and perhaps another 450 patients can receive transplants. It is hoped that by 1973 no patient with end stage renal disease will die because of lack of treatment, but the annual cost of the program would be somewhere above 200 million dollars a year. Since we do not have enough dialyzers for all those that need them at this time, how are physicians to select those to be treated and which ones will be allowed to die?

Categorizing Addicts

The public, as well as the medical profession, is at a loss in categorizing drug and alcohol addicts. Are those addicted to either of these materials sick people? Should they be prosecuted for crimes committed while under the influence of their addictive substance? It was my privilege to be a friend of the man who started the Alcoholics Anonymous in Illinois.

Twelve years ago I also had the responsibility of assisting the son of long time friends who was a very serious heroin addict. Before I saw him this boy had held up a drugstore to get drugs and had spent four years in prison. He "kicked" the

habit and for the past 11 years has held a responsible job. But are these people to be considered criminals when they commit crimes?

Recently it has been demonstrated that aberrations in the XYY sex chromosome are found in a very high percentage of criminals accused of serious crimes. Is this criminal to be executed for his crime because he has inherited a defect that under certain conditions might compel him to commit crimes? Richard Speck, who murdered the eight nurses in Chicago a few years ago, is basing his appeal to the Supreme Court on this chromosomal defect.

Organ Transplants

Organ transplants produce a tremendous variety of new questions on medical morality. The transplant of a paired organ such as the kidney projects no great problem in ethics, but when single organs as the heart, liver or pancreas are transplanted, a host of questions on morality are presented. In other words, if there is no great danger to the donor or the recipient and if permission is given to remove, shall we say one kidney, the ethics we now embrace would cover the operation. But when the donor must die if relieved of his unpaired organ and if the organ does not function in the recipient who has meanwhile lost his inefficient organ during the operation then death is certain for both the donor and the recipient. Since only living tissue can be expected to function in the recipient's body, the donor tissues must be alive when removed. So it is that the definition of death is so important.

Three Areas of Morality

There are three areas of morality in transplants.

First is the physician. Is the welfare of the patient his sole guiding principle or is he subconsciously prejudiced since obviously his reputation will be greatly enhanced by a successful heart transplant?

The recipient. How long would he live without his new heart? What are the chances of tissue rejection? Is the rest of his body sound or will he die of some other pathology soon?

The donor. Is he dead? What is death? Is it morally right to remove his organs

(Continued on page 526)

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

Winnebago Physicians Protest Cohen Action On Premiums

The Winnebago County Medical Society has protested the decision of Wilbur J. Cohen, former secretary of Health, Education and Welfare, to hold the Part B Medicare premium rate at \$8.00 a month. In a letter to U. S. Senators and Congressmen from Illinois, Secretary Donald P. Feeney, M.D., said the society "strongly disapproves of any attempt to selectively prevent or restrict any increase in physicians' fees when no such restrictions exist on other sectors of the private economy." The letter added that this action "will merely result in financial hardship for the physicians as they try to meet both increased costs of running their practice and increased costs of daily living." The society offered to provide statistical examples of the "adverse impact."

ISMS Committee Sponsors Tracts To Curtail Emergency- Room Use

The ISMS Committee on Hospital Relations is mounting a campaign to discourage both physicians and patients from abusing hospital emergency room privileges. Pamphlets sponsored by the committee will cite the skyrocketing cost of ER's—both to hospitals and patients—and suggest ways to avoid needless use and referrals. The pamphlets will be distributed to county medical societies, civic groups—and ER's.

General Assistance In Chicago One-Sixth New York Total

A recent Government survey points out that General Assistance payments totaled \$1,794,000 for 32,100 recipients in June, 1968. Amounts in the other top cities were \$10,901,000 for 148,000 recipients in New York, \$1,023,000 for 25,200 in Los Angeles.

practice management **NEWS**

A Service of the Public Relations and Economics Division

If you're a solo practitioner who's considering forming a group—or a group member wondering if you weren't better off practicing alone—you face two fundamental questions: "Does group practice best serve my patients? Do we physicians benefit by working together?" To help you make your decision, the AMA has prepared the following list of pros and cons both for you and for your patients.

ADVANTAGES AND DISADVANTAGES OF GROUP PRACTICE

ADVANTAGES TO THE PATIENT

Here are some of the principal advantages to patients listed by proponents of group practice.

- + The ready availability of specialists and various technical and scientific services in one location.
- + Better assurance of emergency service when needed.
- + Compilation of a patient's complete medical history in one file.
- + Access to trained administrative personnel to handle insurance matters or financial problems.
- + A better check on each physician's performance by his peers to assure quality medical care.

DISADVANTAGES TO THE PATIENT

And here are some of the disadvantages to the patient.

- + A patient may not like the physician he gets on his first visit to a group and may be reluctant to ask for another physician in the group. The consequence can be a dissatisfied patient.
- + Some feel that group practice weakens the doctor-patient relationship because the total atmosphere is too impersonal.
- + Patients occasionally have unhappy experiences with the business office and condemn the entire clinic organization.
- + Patients sometimes complain that group practices are run on an assembly line basis and that the physicians are more interested in the science of medicine than the personal needs of patients.

ADVANTAGES TO PHYSICIANS

Here are the most frequently cited advantages of group practice for the physician.

- + The opportunity to work regular hours, with time that can be relied on for leisure.
- + The opportunity to leave practice temporarily for vacations or to attend scientific meetings with the knowledge that patients will be taken care of.
- + The availability of technical aides and facilities and ready access to consultation.
- + The opportunity to devote time and talent to professional problems without concern for administrative matters.
- + The stimulation of professional relationships which help improve performance and maintain high quality.
- + The sense of professional and economic security.
- + Fringe benefits, such as insurance and pension programs.
- + The opportunity to enter practice without heavy investment and with reasonable assurance of stable income.
- + The ability to acquire, through group purchase, the best available equipment for administrative functions, for diagnosis and therapy and for research.
- + The elimination of direct monetary relationship with patients, and the availability of competent business management.

DISADVANTAGES TO PHYSICIANS

And here are some of the disadvantages cited by physicians.

- + Each physician member of a group must give up some measure of independence and individualism.
- + Physicians outside the group are sometimes said to be reluctant to refer a patient for consultation to a specialist in the group.
- + Potentially high-earning specialists often do not earn as large an income as they would in solo practice because group income must be divided among all members, including those whose work is less productive although necessary.
- + Each group member shares in, and suffers to some degree, by the errors of his associates.
- + Group members occasionally are committed by group decision to policies of which they disapprove.
- + A group member will sometimes be required to help pay expenses incurred by partners from which he derives no clear benefit, and he will sometimes be restrained in his own expenditures.
- + Group practice sometimes leads to an undesirable degree of over-specialization.
- + Group practice sometimes attracts men who are or become more interested in professional and personal security than in excellence of practice, teaching or research.
- + Disagreement over division of income sometimes arises.
- + Close relationships may lead to personality clashes.

At the regularly scheduled meeting of the ISMS Usual and Customary Fees Committee on March 8, 1969, the IDPA agreement which was previously mailed to all physicians was reviewed with the Department.

The Committee and the Department concurred that a revised agreement form would satisfy the requirements of the new amendments to the Social Security Act. The discussion and the revised agreement form was accepted and endorsed by the ISMS Board of Trustees at its meeting on the same date. The Society is cognizant of the new regulation which was forced upon the Department of Public Aid by HEW. It is to be noted that HEW will withdraw Federal matching funds for medical payments if such signed agreements are not on file for all providers of medical services.

The revised agreement supersedes the previous one dated February 10, 1969. It is essential that this new condensed agreement be signed. Copies of the previously submitted agreement will be destroyed.

Copies of the revised agreement should be returned to the Illinois Department of Public Aid, 1035 Outer Park Drive, Springfield, Illinois 62706.

YOUR ISMS INSURANCE QUESTIONS

QUESTION: I notice that your Professional Liability (Malpractice) Program has different rate classifications for doctors assisting in major surgery on their own patients, and those performing or assisting in major surgery on other than their own patients. Since I come within both classifications, would I pay the premiums for both?

ANSWER: No, you would not. You pay just one premium, and that is for your higher-rated classification as determined by statements in your application for insurance. In your case that would be Class III—major surgery on other than own patients.

Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Ill. 60601. The column is a service of the ISMS Committee on Medical Economics and Insurance.

State of Illinois Department of Public Aid AGREEMENT

The Illinois Department of Public Aid, the State Department responsible for the administration of the Medical Assistance Program under Title XIX of the Social Security Act, hereinafter called the Department, and _____ of _____ hereinafter called the Physician, mutually covenant and agree as follows:

1. The Physician agrees to keep such records as are necessary fully to disclose the extent of services provided to individuals receiving assistance and to furnish the Department with pertinent and reasonable information regarding payments claimed as the Department may from time to time request.
2. This agreement may be terminated by the Physician or the Department at any time upon written notice.

Date

Signature

Director
Illinois Department of Public Aid

AMA Medical Education Number

Address

City

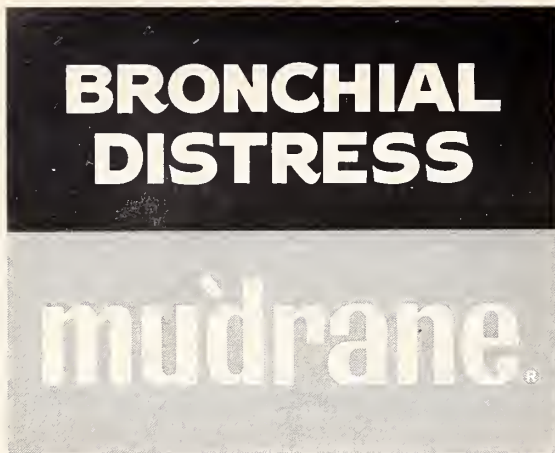
Zip

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"Ouch"

"The most significant financial event of the American College of Physicians in 1968 was the imposition of federal income taxes on the net revenues of the **Annals of Internal Medicine**. These taxes will amount to approximately \$170,000 for 1968 and the budget for 1969 provides for \$285,000 in federal income taxes. Although there remains hope in some quarters that the new regulations, which tax advertising revenues of tax-exempt organizations may sometime in the future be reversed, the prudent course for the College to follow in plotting its financial path is to assume that the tax is an established fact and will remain in effect. This does not mean that we will not pursue whatever avenues that seem to offer some hope of relief. We are and shall continue to keep in close touch with our legal counsel concerning all tax matters." ("The Bulletin of the American College of Physicians." [Jan.] 1969, 10:1, pg. 20. [Actions of the Board of Regents. College Headquarters, Philadelphia, Pa., November 9, 1968.])



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The President's Page

(Continued from page 366)

economies. We could cooperate with boards and administrators in a mutual UR program to control hospital expenses.

Of course, there are many other facets of the health-cost problem. We physicians must help achieve fuller private health-insurance protection for lower-income people. We must help make voluntary Comprehensive Health Planning effective—for by coordinating the delivery of health care we can curb costs. We must exercise restraint in raising our fees.

Because costs inevitably follow the law of supply and demand, we must emphasize one of my favorite themes: medical education. We must demand that the medical schools of our state boost their supply of graduates—quickly and abundantly.

Today's medical crises demand responsibility from us. Let's provide it! Our State Medical Society is our instrument of responsibility. Let's use it!

Philip R. Thorman M.D.

The Doctor's Library

(Continued from page 395)

bectomy while being clear and concise does not mention the comparative long term results of operative versus non-operative treatment.

This monograph, as an outline, is well written and well illustrated. It is a useful starting point for anyone interested in the subject of thrombophlebitis. The information must then be supplemented by referring to the articles in the bibliography and to other books on phlebitis and thromboembolism.

Julius Conn, Jr., M.D.

A study conducted for the Pharmaceutical Manufacturers Association reveals that prices on patented drug products have declined 24.8 percent since 1949, while prices for non-patented drug products have risen 1.1 percent during the same period.

**ILLINOIS
MEDICAL
ASSISTANTS
ASSOCIATION
REPORT**



***Education for the Medical Assistant
in Danville***

BY VIOLA ANDREWS/DANVILLE

The Vermilion County Medical Assistants Association has successfully conducted a class in Medical Terminology as a pilot in our education program. The purpose in starting classes was to promote professional growth for the assistants and to prepare those girls interested in certification with some of the knowledge they will need to pass the examination for the coveted CMA award.

When our program was in the discussion stage, we had no idea as to the amount of interest a course in Terminology would generate. However, our organization decided to sponsor the course and invite anyone working in the medical field to attend. Letters were sent to local hospitals and all physicians' offices describing the course. The local newspaper helped publicize the class. Response was tremendous, with 55 persons enrolling. This included 32 women working in hospitals and 23 employed by physicians. Included in the total were 12 members of the Vermilion County Medical Assistants Association.

Classes were scheduled twice a month, from 7:30 p.m. to 9:00 p.m. A question and answer period lasted 30 to 40 minutes after the class. The only cost to the students for taking the course was \$5.00 for the book, which they keep. The book used as a study outline is *Understanding Medical Terminology* by Sister Mary Agnes Clare Frenay, SSM, published by the Catholic Hospital Association.

We were very fortunate in securing a former teacher from the Lake View Hospital School of Nursing, Mrs. Betty White, R.N., to outline the course, instruct us in some sections and arrange for lectures for other sections. Mrs. White has taught Orientation of Terminology, Disorders of the Skin and Breast, Musculoskeletal, Respi-

ratory, Urogenital Disorders, and Diseases of the Body as a whole.

Doctors have lectured on Digestive Disorders, the Nervous System, Ear, Nose and Throat, and the Endocrine System. To have doctors take time from their crowded schedules to prepare and lecture to the class has been an added encouragement to all of the students.

The Vermilion County Medical Assistant Association feels it has provided a service to the community in promoting this course. Even though many of the students were adept in the terminology that applied to their particular job, the knowledge they have gained will be of benefit throughout the years.

Plans to offer a course in Medical Law and Economics as the next step in our program are being worked out. VCMMA has asked the Danville Junior College to help us in setting up this class and we hope it will be offered as a part of the Adult Education curriculum. Included in this course will be sections on Medical Ethics and Governmental programs which provide aid or assistance to many persons in our community as well as a section on the laws pertaining to a medical practice of which the assistant should have knowledge.

The American Association of Medical Assistants, Inc. (office at 200 East Ohio Street, Chicago, Illinois) has excellent literature to facilitate setting up classes. This is available at no cost and provides names of books suggested for study programs. Outlines are given stating area of knowledge required to become a competent medical assistant. Anyone interested in starting a class will receive literature and suggestions promptly by writing to the address shown above.

Here's some Professional Advice (on vacations)

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THE VIEW BOX

(Continued from page 394)

The herniation of the transverse colon through the Foramen of Morgagni caused a gastric outlet obstruction in a normal stomach by compressing the anterior wall of the stomach as it entered into the chest through the left Foramen of Morgagni. A Foramen of Morgagni hernia can be suggested when radiographically the stomach appears in a high transverse position with the distal body of the stomach drawn upward if the stomach is within the herniation itself. In this particular case the stomach was not confined within the hernial sac. The transverse colon will go up in an inverted "V" fashion and is noted as multiple radiolucencies behind the cardiac border. Foramen of Morgagni hernias are among the rarer type of herniations which occur through the diaphragm and should be considered in any case in which loops of bowel are seen within the confines of the chest cavity in an anterior location. Following the surgical release of the hernia the patient's gastric obstruction quickly subsided.

Alcoholism Treatment Program

(Continued from page 393)

sions which are open to patients who have completed the treatment program.

The center itself is a five-story building, three stories above ground and two below. Total cost of the new, expandable center is \$2,600,000. This is being raised by the hospital from concerned corporations, foundations, individuals and organizations. A \$325,000 federal grant was also obtained. This was the first time that a Hill-Burton grant had been made for an alcoholic treatment facility.



**You Work 2½ Hours a Day for
the Government**

Employed Americans will work two and a half hours every eight-hour working day in 1969 to pay their tax bills—federal, state and local, according to tax experts of the Chamber of Commerce of the United States. The 10% surtax accounted for a big jump in federal taxes, but state and local taxes are also showing a distinct upward trend.



The Public Affairs Library is a new addition to the Illinois State Medical Society public affairs program. Each month in the JOURNAL, one or two books will be reviewed for physicians and their wives. The book topics will include politics, legislation, the Supreme Court, political parties, lobbying, and related governmental subjects. Books may be borrowed or purchased from ISMS. Write to Public Affairs Library, Illinois State Medical Society, 360 N. Michigan Avenue, Chicago, Illinois 60601.

THE PEOPLE'S PRESIDENT.—Neal R. Peirce, Simon and Schuster, 1969, \$8.95.

The controversy over the electoral college has waxed hot and cold intermittently since the inception of the Constitution. It is ironic that despite the long history of the dispute, most voters assume they are voting directly for the President. It wasn't until the recent flurry caused by George Wallace that people became aware of the impact of electoral votes.

Neal Peirce's book is timely and is *the* definitive work on the electoral college and the direct-vote alternative. The author dispassionately examines and compares pros and cons of the electoral college and other systems: the Proportional Plan; the District Plan; the Automatic System; the Direct Vote Plan. Of these plans, Mr. Peirce favors the direct vote for President contending that it is manifestly unfair and risky to continue the electoral college system which leaves the possibility of a candidate winning the electoral college vote and losing the popular vote. "The choice of the Chief Executive must be the people's, and it should rest with none other than them," he believes. He is in basic agreement with the constitutional amendment to provide for the direct popular vote for President that was introduced by Sen. Everett Dirksen and Rep. Emanuel Celler (D-N.Y.) in 1967. Section 3 of the Amendment reads:

"The persons having the greatest number of votes for President and Vice President shall be elected, if such number be at least 40 per centum of the whole number of

votes cast for such offices. If no person has such number, a runoff election shall be held in which the choice of President and Vice President shall be made from the persons who received the two highest numbers of votes for each office."

The nationalization of American politics, Mr. Peirce points out, has resulted from the development of the two-party system in states previously dominated by one party and the movement toward universal suffrage. And these trends have been shaped by the revolution in educational standards, the high standard of living, a mobile population and the impact of news media—especially television. The text also covers questions frequently asked about the direct voting plan and other systems of electing a President and Vice President.

Neal Peirce is the Political Editor of *Congressional Quarterly* and exhibits his knowledge and perception in this interesting book.

THIS HONORABLE COURT.—Leo Pfeffer, Beacon Press, Boston, 1965, \$3.45.

This Honorable Court is a complete history of the U.S. Supreme Court. Although the author's account is factual, it is well spiced with landmark cases of interest to the reader. The text covers the beginnings of the Court, its temporary abolition, its Chief Justices, landmark cases, legal domain and structure. Author Pfeffer explains in depth the nuances of decision making and the inherent problems in making judgment.

(Continued on page 524)

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Public Affairs Library

(Continued from page 523)

A three-fold paradox becomes obvious while viewing the Court: First, a high judicial tribunal, operating within judicial customs and using judicial instruments, exercises important political and legislative functions. Second, in doing so, it makes many enemies in highly important and influential circles, and yet escapes any effective attack upon its status or its powers. Third, all other agencies of government, federal and state, accept these political and legislative decisions even though the judicial tribunal has absolutely no weapon in its arsenal that could be employed to compel compliance on the part of anyone.

Where lies the answer to this triple paradox? Where does one find the solution for the riddle of a court that exercises political power not possessed by any other tribunal in the world and yet has no means whatsoever at its disposal to defend that power if it were seriously challenged? How does it come about that the Court, which throughout its troubled and contentious life has continually made enemies among the most influential segments of the nation, nevertheless enjoys such a prestige and status?

In relating the Court's complete history, Mr. Pfeffer shows that the Court does not deem its function to be the correcting of incorrect decisions by lower courts or even the prevention of a miscarriage of justice. Unless there is an important issue of federal law presented, the Court will refuse to accept an appeal even if the Justices individually might believe that the lower court was wrong in its decision.

A former Congressman from New York, Timothy Campbell, was once quoted as saying "What's the Constitution among friends?" Leo Pfeffer has written an interesting and powerful answer.

Illinois . . . the Tall State . . . is a capsule of America—a concentration of all elements that make the American economic system strong. Virtually no other economic area has made of itself what Illinoisans have made of their state.

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

MARION COUNTY: Iuka; population: 400. Trade area, 2,000. No resident physician. Nearest physicians and hospitals at Salem, Centralia, and Olney, 10 to 30 miles; St. Louis, 80 miles. No drug store. Financial assistance if desired. Predominant nationality: German and English. Agricultural area. Churches: Baptist, Methodist and Lutheran. One grade school; bus service to nearest high school at Salem. Active Masonic Lodge. Nearest recreational facilities at Salem, 10 miles. For further information contact: Mr. Harold Henne, Box 162, Iuka; Mrs. Evelyn Howe, L.P.N., Iuka.

MARION COUNTY: Salem; population: 6,200. Only 4 physicians as compared to 8 in the past: ages 52, 56, 58 and 75. Present number completely inadequate according to county medical society. Forty bed hospital; 65 miles from St. Louis. New Brown Shoe Company just completed; 3 new industries starting. Churches: twenty Protestant and Catholic. Public and parochial schools. Local country club with golf course and swimming pool; 20 miles from Carlyle Lake. Financial inducements to newcomer. For further information contact: F. C. Katzenstein, M.D., Salem. Phone: 618-548-0152.

MARSHALL COUNTY: Henry; population: 2,500. Trade area, 15,000. After practicing here 9 years one of 2 doctors moved

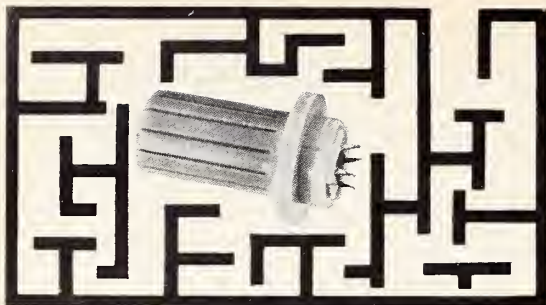
to enter practice in wife's home town. Only doctor is 45 years of age. Nearest hospital at Spring Valley, 25 miles; 35 miles from Peoria. One prescription drug store. Seven room office building erected in 1957 by physician, available if desired—for rent or for sale with or without equipment. Agricultural and industrial area. Churches: four Protestant and two Catholic. Public and parochial schools. Nearest country club 7 miles. For further information contact: W. L. Bayne, D.D.S., Henry.

MARSHALL COUNTY: Wenona; population: 1,000. Trade area, 3,500. One physician in limited practice. Nearest hospital at Streator, 18 miles; Peoria, 18 miles. Prescription drug store. Office of former physician available if desired; 5 rooms, central air conditioning, gas heat. Agricultural and industrial area. Churches: Catholic, Methodist, Presbyterian and two Lutheran. Grade and high schools. Active Chamber of Commerce, Masonic Lodge. For further information contact: Chamber of Commerce, Attn: J. R. Kurrle, Wenona. Phone: 853-4519.

MASON COUNTY: Havana; population: 5,000. Trade area, 25,000. Three physicians; need for additional. Mason District Hospital; 50 miles from Springfield and Peoria. Two drug stores. Office space available. Equipment of a former physician and financial assistance available if desired. Agricultural area. Churches: eleven Protestant and Catholic. Grade and high schools. New 9 hole golf course. For further information contact: Mrs. Eleanra Gilson, Secretary, Community Service League, 635 S. Broadway, Havana. Phone: 543-2134.

MASSAC COUNTY: Metropolis; population: 8,000. Trade area, 25,000. Five physicians; one recently moved for residency; second had coronary. Massac Memorial Hospital here; 80 miles from Evansville, population: 138,500. Four prescription drug stores. Two former physicians' offices and financial assistance available if desired. Predominant nationality: German. Churches: Protestant and Catholic. Grade and high schools; 60 miles from Southern Illinois University. Country club with golf

(Continued on page 526)



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Medical Morality

(Continued from page 508)

without his consent? Does the doctor murder the donor when he removed his heart? All of these problems present a new dimension defined as "value judgment." What are the chances for the patient's continued life and how much will this life be worth in terms of happiness? Are we merely prolonging the death of the patient during which his suffering will be greatly increased and the burden on the family intolerable?

It is obvious that physicians must be responsible for an opinion on the patient's physical state and the possibility of rehabilitation if extraordinary measures are undertaken. More than one physician should share this responsibility with any patient. From this point on, however, society as a whole, with the assistance of the clergy and the legal profession, must decide what is morally right and what should be done. These guide lines must be reinforced by laws—else the physician may find himself accused of murder. ◀

Placement Service

(Continued from page 525)

course. City swimming pool located on beautiful Ohio River. For further information contact: Eugene Cowser, Administrator, Massac Memorial Hospital, Metropolis. Phone: 618-524-2176.

MARION COUNTY: Centralia; population: 15,000. Trade area, 50,000. Twenty physicians in community; need for more according to secretary of county medical society. New accredited hospital—St. Mary's, 110 beds, being enlarged to 150. Fifty-five miles from St. Louis. Four drug stores. New Medical Arts Bldg. with ground floor offices located in downtown district includes complete lab facilities plus offices built to individual's specifications. Agricultural and Industrial area. Grade and high schools. For further information contact: Walter Plassman, M.D., Warren Murray Children's Center, Centralia.

Illinois' yearly unemployment averages 3.1 percent, the lowest of any industrial state.

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Meeting Memos

(Continued from page 498)

May 20—St. Mary of Nazareth Hospital

General Medicine Lecture Series Program
"Microbacteria Other Than M. Tuberculosis"
1120 N. Leavitt St., Chicago

May 22-23—American Medical Association

4th Conference on International Health
"U.S. Efforts in Intl. Health Today & Tomorrow"
LaSalle Hotel, Chicago

May 24—International Society of Gastroenterology

Drake Hotel, Chicago

Sept. 9-11—Cook County Graduate School of Medicine

6th Summer L. Koch Hand Surgical Symposium
Chicago

Evaluation of Pap Smear

(Continued from page 411)

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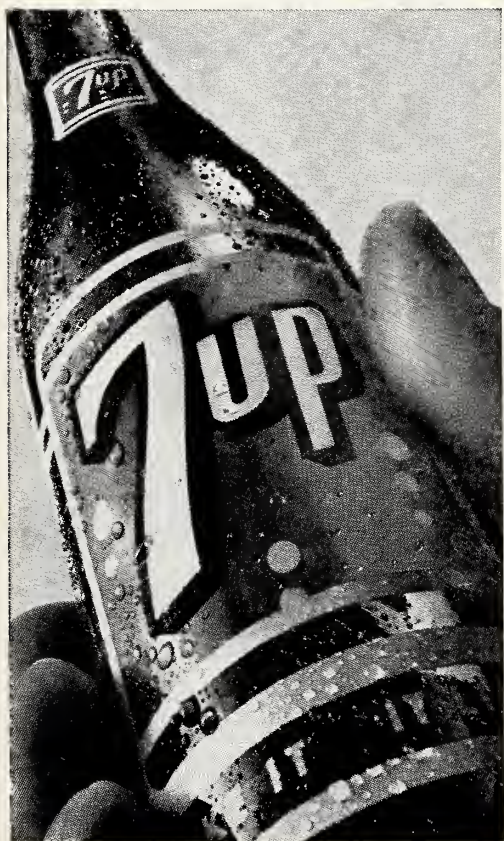
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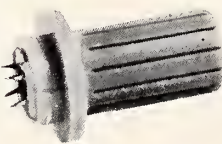
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472-9

OBITUARIES

Dr. Luis Bay, East Moline, died Feb. 9 at the age of 44.

***Dr. Richard Burrows**, Chicago, died March 2 at the age of 70.

***Dr. Isaac S. Evans**, Sycamore, died Nov. 30 at the age of 90.

***Dr. Bronius Gaiziunas**, Chicago, died Feb. 1 at the age of 58.

Dr. Clarence O. Haley, Mountain View, Calif., died Oct. 20 at the age of 78. He formerly practiced in Chicago, where he was affiliated with the Garfield Park Hospital.

Dr. James J. Hennessy, Chicago, a physician for more than 50 years, died Feb. 27 at the age of 76.

***Dr. Percy W. Kensler**, Lawrenceville, died Feb. 3 at the age of 77. He was past vice-president of the National Eclectic Medical Association.

Dr. Maria A. Langford, Hinsdale, died Feb. 9.

Dr. William R. Mangum, Bridgeport, died Jan. 28. He served as Lawrence County Coroner, secretary of Bridgeport Township High School Board of Education and was a member of ISMS Fifty-Year Club.

***Dr. Warren C. Miller**, Algonquin, died Feb. 4 at the age of 44. He was a fellow of the American College of Surgeons.

Dr. Philip M. Nabbe, Des Plaines, died at the age of 66.

***Dr. Emil Oelke**, a Wheaton physician for 56 years, died Feb. 12 at the age of 95.

***Dr. Mario Prioletti**, Wilmette, died March 1 at the age of 45.

Dr. Norbert J. Roche, Cary, died Feb. 7. He was a staff physician at St. Francis Hospital, Evanston, for 33 years.

***Dr. Carl G. Sachtleben**, Chicago, a physician for more than 50 years died Feb. 10 at the age of 79. He was past treasurer of the Illinois Academy of General Practice.

Dr. Arthur Schwarcz, Chicago, a physician for 46 years, died Feb. 15 at the age of 73.

*Indicates member of Illinois State Medical Society.

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BLUE SHIELD REPORT



FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 222 NORTH DEARBORN AVENUE • CHICAGO, ILLINOIS 60601

Vol. 3, No. 5

May, 1969

Summary of Annual Report, 1968

The Blue Shield Plan of Illinois Medical Service recently completed its annual report and we are happy to announce that we have experienced important increases in both membership and in benefits for professional services rendered its members during 1968. Membership in Blue Shield's regular programs increased 139,465 during 1968 to 2,410,839.

Blue Shield provided benefits for 676,451 claims in 1968. Another 733,366 claims for services rendered were paid under Part B of Medicare—the voluntary medical-surgical portion of the Medicare program administered by Blue Shield in the metropolitan Chicago area. In total, Blue Shield provided benefits on 1,409,817 claims during 1968 under both its regular and governmental programs.

Blue Shield benefits provided under the Plan's regular programs totaled \$32,170,768, an increase of \$5,740,356 over 1967. Plan income for the year amounted to \$39,179,499, up from 1967 by \$5,269,761. At the same time, Blue Shield's operating expense amounted to 9.2 percent of income holding operating costs at the 1967 level.

Added to the administration of Blue Shield's regular benefit programs in 1968 was the Plan's provision of \$46,995,504 in benefits under Medicare. Under both regular and government programs, Blue Shield provided over \$80 million in benefits.

Blue Shield's new "Usual and Customary" program, designed to pay physicians' charges in full, and another designed to pay 80% of usual charges were offered to groups of different sizes.

The increasing cost of care is an area of vital concern to Blue Shield. We work closely with physicians in the exploration and implementation of programs to gain maximum benefit from the prepayment dollar.

One such effort encourages the expanded use of Utilization Review Committees within hospitals. The physicians on such committees review the need for the patient's admission to the hospital and for all services performed while the patient is hospital-

ized. Physicians working together in this manner ensure that the quality of care is maintained and that all necessary care is provided.

Our Recertification program—which periodically examines the need for continued hospitalization—is still another means of saving expensive days in the hospital.

A number of new programs were developed with Blue Cross last year to provide a wide range of service to members. Our new Outpatient Diagnostic Program covers physicians' fees for diagnostic testing when related to specific conditions on an outpatient basis.

Our Pre-Admission Testing Program enables physicians to provide Blue Shield patients the pre-operative tests they require without hospitalizing them when hospitals have agreed to participate in the program.

New developments took place in the Medical Division during 1968. Training seminars for medical assistants were begun in our headquarters office and programs for medical societies and specialty societies were increased. A Blue Shield report is published monthly in the ILLINOIS MEDICAL JOURNAL. A program to contact new society members and student health professional societies was undertaken.

We believe that the expansion of our programs to the profession enables us to provide greater service to our members. Professional support has made Blue Shield preeminent in its field. We will continue to build upon it to improve our services in the coming years.

Robert M. Redinger
Executive Vice President

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Coverage and Limitations for Drugs and Biologicals

Drugs and Biologicals are covered by Medicare if they cannot be self-administered; if they are not immunizations; if they are reasonable and necessary for the diagnosis or treatment of the illness or injury; and if they meet the general requirements for covered items "incident to" a physician's services. For example, the drug must be administered by the physician or by his nurse under his personal supervision and the charge, if any, and name of the drug must be included in the physician's bill or the SSA 1490 claim for payment form.

Prescribed and nonprescribed drugs and biologicals purchased by or dispensed to a patient are not covered.

Whether a drug or biological is a type that cannot be self-administered is based on the usual method the drug form is administered. Thus, oral medications are usually self-administered and therefore not covered. Likewise, when a physician gives a patient an injection which is usually self-administered (insulin, for example), payment is disallowed except in an emergency situation such as a diabetic coma. However, when a physician injects a patient with a drug which is not usually self-injected, it would not be excluded even though the drug may be available in oral form.

Vaccinations or inoculations are excluded as "immunizations" unless they are directly related to the treatment of an injury or direct exposure to a disease. Preventive immunization is not covered.

Injections must be necessary for the diagnosis or treatment for an illness or injury before Medicare payment can be made. The injected drug must be named and indicated as a specific or effective treatment for the particular condition for which it was given and reported on the SSA 1490 Request for Payment form or on the itemized statement. Injections given for purposes other than treating a particular condition, illness or injury are not covered under Medicare.

Filing for Assigned Claims

PATIENT'S SIGNATURE ON ASSIGNED CLAIMS: The patient must sign the Medicare Request for Payment form 1490 whenever the physician accepts an assignment. This is done to indicate that the patient has agreed to assign and the physician on the same form indicates that he has agreed to accept thus preventing disagreement over who should receive the Medicare payment.

PATIENT UNABLE TO SIGN: A patient who is physically unable to sign may have his claims signed by a relative. The relative should sign the patient's name, his own name, and their relationship, i.e., "Mary Jones by John Jones, son". There should be a statement explaining why the patient was unable to sign. (See reverse side of Form 1490 item #6.)

EXTENDED COURSE OF TREATMENT: A physician treating a patient over an extended period does not have to obtain the patient's signature each time he accepts an assignment. However, he can obtain the patient's consent to an assignment of unpaid charges for the anticipated period of treatment by having the patient sign a brief statement as follows: "I request that payments under the medical insurance program be made directly to Doctor _____ on any unpaid bills for services furnished me by that physician during the period _____ to _____". However, the period should extend no later than the close of the calendar year. A copy of the signed statement should be attached to a 1490 claim form and submitted as usual. Subsequent claims should then be submitted with the statement below. When the physician submits the 1490 form for assigned payments, he should indicate in the patient's signature space, "This is a continuation of a course of treatment for which patient's assignment was previously obtained."

Ledger-Type Bills Pose a Processing Problem

A delay in payment can result if a running ledger type bill is submitted with a Medicare Request for Payment form 1490. Many times this type of bill will list not only unpaid charges but many times they will also list charges which have been previously paid or disallowed. This means that the claim must be manually checked to determine exactly what portion of the bill has been previously processed.

To avoid delay, carefully check all bills, the ledger-type in particular, to make sure none of the charges have been previously submitted.

(This is not an advertisement)

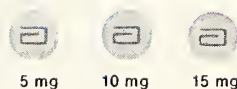
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For patients who can't take plain amphetamine

Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride, 60 mg. Sodium Pentobarbital



Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride, 90 mg. Sodium Pentobarbital



THE PROGRAM—3 Patient Booklets



Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. Food exchanges and a comprehensive list of foods, showing their calories, are also included.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

Compact new booklet features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

902110



Please see Brief Summary on next page.

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BRIEF SUMMARY

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in Long-Release Dose Form

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Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates, or in those with history of manifest or latent porphyria.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Because of its sodium pentobarbital content, use Desbutal with caution in patients receiving coumarin anticoagulants. Pentobarbital may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

902110



Clay and Starch Eaters

An expectant mother who eats clay and laundry starch can hurt both herself and her child.

The eating of clay and laundry starch was found to exist in a group of 61 indigent women, primarily Negro women of Southern U. S. origin, who were studied at Chicago Lying-in Hospital by a University of Chicago team.

The medical team found that 16 per cent of the women were including laundry starch in their diet and another 6.6 per cent ate clay.

Most of the clay eaters shipped it in from the South. They favored the white Georgia clay—kaolin—but a few were partial to the light pink or light blue clay found in certain southern states. The starch eaters usually prefer a particular brand which is available in nearly all grocery stores.

Both substances provide an exotic—but not harmless—touch to the diet, according to Dr. Joseph R. Swartwout, Associate Professor of Obstetrics and Gynecology in The Pritzker School of Medicine of the University, and Miss M. Bertha Brandt, Nutritionist and Research Assistant at Chicago Lying-in.

Dr. Swartwout explained that clay contains no calories, which might be considered a plus for weight-watching pregnant women. However, it contains no nutrients either and, what is worse, it bonds iron in the intestinal tract so that it passes through without being absorbed. Another negative factor is that the bulk usually reduces the capacity to consume other foods that contain much-needed proteins.

Laundry starch, on the other hand, contains calories, all in the form of carbohydrates. It gives the user a feeling of fullness, leading her to skip other essential nutrients.

The end result, if unchecked, can be severe iron deficiency anemia in both mother and child. Dr. Swartwout said there has been some suspicion that such dietary habits may cause an increase in the incidence of prematurity, but this has not been established.

* * *

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Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsic.	30.0 mg.	—
Ascorbic acid	100.0 mg.	—

Contains 15%
alcohol†
† Some Loss
Unavoidable.

Contraindication: Carcinoma of the prostate, due to methyltestosterone component.

Warning: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

Side Effects: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

Suggested Dosages: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

Supplied: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.

No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.



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The president's page

Where's The Action?

Every year we hear about new legislative activity aimed at improving health care, extending health care, preventing abuses, and so on. But where does the physician fit in?

He fits in at the center of the whole concept of government and health activity. It is imperative that he become the model of concerned individual action—the physician is the keeper and keystone of health. He must be responsible and act responsibly. And this extends, also, to *action* to influence legislation.

How many physicians are aware of the fact that many bills currently introduced in the Illinois Legislature and U.S. Congress concern the basic practice of medicine? How many are aware, for example, that a bill rumored to be dropped into the Illinois hopper, would increase physician license fees 300%? The present fee of \$10 every two years may be changed to an annual \$15. Have individual physicians expressed themselves in this—have they made *any* of their feelings known?

A recent piece of legislation introduced in the U.S. Senate (S-111) provides that payment for physician's services under Part B of Medicare would be on the basis of a "reasonable allowance." Likewise, S-1195 authorizes restrictions on hospitals as to the amount they can be paid by Medicare and Medicaid for services rendered to eligible beneficiaries.

Government regulated medicine? To be sure. But these are in the discussion stage. Medicine still may be heard.



Philip G. Thomsen, M.D.

The U.S. Senate Finance Committee has been seeking information on M.D.'s who were paid more than \$25,000 under Title XIX during 1968. While the search for abuses may be necessary, how many, though innocent, may be defamed or jeopardized by implication? Can medicine afford *not* to be concerned with this inquiry?

Other Congressional items I feel we all must watch and study: extension of Hill-Burton (H.R. 6797 and H.R. 7059); generic vs. brand name prescribing and compulsory regulation of prescribing practices; Regulation of Trade in Drugs Act (S-1402); the placing of a health warning on alcoholic beverages (S-1388). Of particular concern is the establishment of a method for limiting costs through establishing a fee schedule for physician's services.

In all of these I detect an attempt to impose restrictions on medical practice—to infringe into areas not regulable or which should be controlled by medicine. And I feel we must be heard in these matters.

Closer to home we must be concerned with items being considered in the Illinois House and Senate. And we must be more than concerned—we must translate concern into Action!

Our House of Delegates took no position on the question of abortion law modification other than to recognize a serious, multifaceted problem. The subject of artificial insemination has never been dis-

(Continued on page 557)

Abstracts Of Board Actions

Meeting March 8-9, 1969—Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

REPORT OF THE PRESIDENT

ISMS President, Philip G. Thomsen, briefly summarized the activities of the Public Affairs "Roundup" held in Washington, D.C., February 16-18. Dr. Thomsen reported that he, Dr. Frank J. Jirka, Jr., Chairman, ISMS Board of Trustees and Roger N. White, ISMS Executive Administrator, met with various members of Congress and discussed the problems of medical education; including ways in which funds—now being used for research purposes—might be used to educate more physicians and increase medical school enrollments.

DEPARTMENT OF PUBLIC HEALTH

Dr. Franklin D. Yoder, director, Illinois Department of Public Health, reported that the State was presently considering establishing a new department to deal with the air and water pollution problems and the conservation problems in Illinois. Dr. Yoder indicated that these areas may soon be dealt with through a new Department of Natural Resources.

EXECUTIVE COMMITTEE REPORT

Dr. Frank J. Jirka, Jr., reported that the Executive Committee had met with the deans of the five medical schools in Illinois regarding a proposal to request the State of Illinois to provide a subsidy to private medical schools based upon the number of additional students enrolled, irrespective of their state of residency. He noted that ISMS, as well as the medical schools, is doing everything possible to effect this type of legislation from the 76th General Assembly.

In the course of his report, Dr. Jirka also indicated that the Executive and Finance Committees had approved scheduling a reception at the AMA Convention in New York City in July in honor of Dr. Walter C. Bornemeier, who will be nominated by the ISMS delegation for the office of AMA President-Elect. This reception will be in lieu of the luncheon generally sponsored by ISMS at this time.

NO CHANGE IN DUES STRUCTURE

The Board of Trustees voted at its March meeting to recommend to the 1969 House of Delegates that the 1970 ISMS dues structure remain the same as for the year 1969. The breakdown of dues is as follows:

Total dues\$105.00

AMA-ERF\$20

Benevolence 5

HCCI 2

Reserves 8

Operating fund 70

—
\$105.00

POLICY COMMITTEE ACTS ON REBATES

Dr. William E. Adams reported that the Policy Committee will submit the following statement to the 1969 House of Delegates for its approval at the annual meeting on May 18-21:

"In conformity with AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical."

In addition, Dr. Adams reported that the Policy Committee has approved a statement calling for the establishment of local county or multi-county health departments where none now exist and that county medical societies, as well as physicians, should give their wholehearted support to this effort.

ESTABLISH NEW MEDICAL LIBRARY

In his report of the Third District, Dr. William E. Adams indicated that the Midwest Regional Science Library project has been finalized and that work is already underway to organize this project to serve the five midwestern states of Illinois, Indiana, Iowa, Minnesota and Wisconsin. The library will be maintained by the John Crerar Library at the Illinois Institute of Technology, Chicago.

Four areas of service activities will be provided:

1. Services within the library
2. Document services
3. Information services
4. In-service training program for health science library personnel.

OSTEOPATHS IN ILLINOIS

In his report for the Seventh District, Dr. Arthur F. Good-year indicated that there were presently four qualified osteopaths in the Decatur-Macon Hospital. Dr. Scrivner, Tenth District, reported that two osteopaths have attended meetings of the local medical society in Washington County.

HEALTH MANPOWER STUDY SUGGESTED

Dr. Willard Scrivner called attention to the movement underway nationally—to license sub-professionals—as a solution to the manpower shortage problem. He recommended a study of possible state legislation as an offsetting potential to national licensure. Dr. Scrivner suggested that the Illinois delegation to the AMA present a resolution on this subject at the July meeting in New York calling upon other states to be prepared with guidelines to insure nationwide public protection in the area of health manpower.

MEMBERSHIP ELIGIBILITY LIST SUGGESTED

Dr. Scrivner also suggested that ISMS establish a list of qualified and eligible physicians to serve upon various state committees and commissions which are appointed from time to time by the Governor. Dr. Scrivner noted that this action would greatly facilitate these types of requests and eliminate a great deal of time consuming research.

(Abstracts continued on page 623)

President's Page

(Continued from page 546)

cussed. This has not allowed medicine to be heard in unison.

But in other areas the ISMS, through its various committees and the Council on Legislation, has been heard—the voice of medicine was not crying in the wilderness.

We have supported and had modified a Driver's License Medical Advisory Board Bill (S.B. 425), H.B. 1166, changing the requirements that a Director of Mental Health be a psychiatrist, may prove controversial. Only three states do *not* require this. It is considered by our Council on Legislation to be a step backwards, if not passed. We must express ourselves on this.

A 19-0 "do pass" Judiciary Committee vote on the Blood and Tissue Bill (H.B. 616) reflects concerned, concerted physician action.

In the 76th General Assembly, 1,443 bills have been introduced, at this writing. This is 300 more than during the same period of time last session. Of these, 24 are of primary concern to medicine, while another 72 are of secondary concern. Some of these, the Uniform Anatomical Gift Act (H.B. 78) and H.B. 29, modifying the penalty for first offence possession of marijuana, are quite newsworthy. They have been reported extensively. Space precludes discussing all 96 at length. But they are all most important!

And it is imperative that we speak out on these!

We can speak through our Council.

We can speak through our committees and through our House of Delegates.

We can speak through membership in IMPAC and AMPAC.

Speak, we must! And to speak directly to our representatives and through our society will help to fashion legislation acceptable to free exercise in our professional medical practice.

As I said earlier, the physician is the keeper of health. He must act responsibly. And he must translate his feelings into Action!

During the past year I have talked about many things in this monthly message. I have had the privilege of discussing diverse items on my President's Tour and with the media. I appreciate the opportunities. Your comments and suggestions also have been extremely helpful. As I conclude my term I only regret that I cannot continue to meet with so many of you to help formulate important positions.

But just talking wouldn't accomplish anything. As I leave office, I dedicate myself to Action in the cause of professional medicine. Action by writing my representatives about important items. Action in getting additional practitioners in Illinois. Action in expanding medical school enrollment. Action in withstanding the inroads of government regulation of medicine.

Will you join me through *your* Action?

Philip K. Thomson M.D.

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ON THE COVER

Spring is in the air and summer is in the offing. A vernal scene, depicting the carefree joys of youth, brings to mind fond remembrances—on anticipation of the season allowing greater freedom and recreation.

A portrayal of carefree activity and enjoyment, hopefully, will convey to our readers the hope that theirs will be a happy and gay vacation period—that we will all benefit by relaxing and being refreshed.



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The Management of Respiratory Insufficiency In Myocardial Infarction

BY REUBEN M. CHERNIACK, M.D./WINNIPEG, MANITOBA, CANADA

Respiratory insufficiency occurs whenever there is a diffusion defect, altered ventilation/perfusion ratios, true venous admixture, alveolar hypoventilation, or any combination of these disturbances develops. In patients with myocardial infarction, hypoxia is a common occurrence. This presumably is due to pulmonary congestion which results in altered ventilation/perfusion ratios. When the infarction is complicated by shock there is metabolic acidosis, severe hypoxia and often hypercapnia. These disturbances further affect the function of the heart as a pump, interfere with circulatory homeostatic mechanisms and predispose to cardiac arrhythmias. The therapy of these disturbances should consist of intensive attention to correction of the acidosis, restoration of the arterial blood gas tensions to normal by the administration of oxygen, maintenance of an adequate alveolar ventilation, and early recognition and prevention of severe cardiac arrhythmias. This is best accomplished in a unit especially designed for this purpose and staffed with highly trained nursing, resident and technical staff who are capable of recognizing emergencies and dealing with them immediately.

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Respiratory insufficiency implies that there has been a failure of the respiratory system to supply sufficient oxygen to the blood and to maintain a normal arterial pressure of carbon dioxide, so that hypoxia, either alone, or in combination with hypercapnia, develops. Insufficiency for oxygen exchange or hypoxia, is usually the earliest manifestation of respiratory insufficiency, while inadequate carbon dioxide elimination, in association with the hypoxia, usually develops later.

Pathophysiology of Respiratory Insufficiency

Respiratory insufficiency may be present as a result of several physiological disturbances:-

1) A diffusion defect, which occurs when the quality of the alveolar capillary membrane is altered, as in pulmonary fibrosis, or when there is a reduced pulmonary capillary bed available for diffusion as in pulmonary thromboembolic disease or in diffuse obstructive emphysema.

2) A venous to arterial shunt within the heart or the lungs. In this case there is admixture of hypoxic and hypercapnic blood with arterialized blood.

3) Altered ventilation-perfusion ratios throughout the lung, due to either uneven ventilation or uneven perfusion, or both. When there is perfusion of poorly ventilated alveoli (venous-admixture-like perfusion), this blood will have a higher than normal carbon dioxide tension in association with the hypoxia. On the other hand, if a sufficient number of the remaining adequately perfused alveoli are hyper-ventilated, carbon dioxide retention will not develop. When areas of lung are ade-

quately ventilated but poorly perfused (dead-space-like ventilation) hypoxia does not develop, unless the ventilation of the remaining alveoli is inadequate relative to their perfusion. This latter situation is, of course, venous admixture-like perfusion, and hypoxia and hypercapnia will again be present.

4) Alveolar hypoventilation, which will occur whenever the physiological dead space (that part of the tidal volume which does not take part in gaseous exchange) increases, without a proportionate rise in minute ventilation, or whenever the minute ventilation falls. The alveolar ventilation controls the alveolar CO_2 tension (and arterial pCO_2); for at any given level of metabolism and CO_2 production, a change in alveolar ventilation will result in an inverse change in alveolar pCO_2 . Thus a fall in alveolar ventilation without a proportionate fall in CO_2 output, or an increase in CO_2 production without a comparable increase in alveolar ventilation, will result in a higher than normal arterial CO_2 tension. This hypercapnia is always accompanied by hypoxia, unless the patient is inhaling an oxygen enriched mixture.

Diagnosis of Respiratory Insufficiency

The clinical manifestations of respiratory insufficiency are non-specific and the correct diagnosis of this disturbance will only be made if the attending physician is suspicious of its presence. Unfortunately, unless it is extremely obvious, it is virtually impossible to assess the degree of hypoxia present or the adequacy of the alveolar ventilation clinically. Cyanosis, if present, is a sign of severe hypoxia, but conversely severe hypoxia may be present without cyanosis. Clinical judgment of adequate chest movement, and the stethoscopic assessment of adequate aeration is not a reliable indication of an adequate alveolar ventilation. The definitive diagnosis of respiratory insufficiency can only be obtained by analysis of the arterial blood.

When respiratory insufficiency is present, analysis of the arterial blood will reveal the presence of hypoxia, while the additional finding of an elevated CO_2 tension will establish the presence of alveolar hypoventilation. In acute respiratory failure, arterial pH will be low but the total CO_2

content may be little elevated, and the calculated whole blood buffer base (Singer and Hastings), an index of alkali reserve, is normal. In chronic respiratory failure, on the other hand, there has been compensation for the elevated pCO_2 through elimination of chloride and retention of base and bicarbonate. As a result, pH may be low normal and the CO_2 content, and whole blood buffer base are high. In addition, the serum chloride is low and the serum potassium may be elevated.

Uncomplicated Myocardial Infarction

In patients with myocardial infarction not complicated by shock, the cardiac output and stroke volume vary from normal to very low figures but systemic vascular resistance is increased so that the blood pressure is maintained at moderate to normal levels. If left ventricular failure occurs, with pulmonary congestion and possibly pulmonary edema, respiratory insufficiency develops. With pulmonary congestion the compliance of lung falls considerably, and the resistance to airflow increases three- or four-fold. The resistance is highest in early inspiration and late expiration and may be due to edema of the airways and free fluid in the tracheo-bronchial tree.

In moderate degrees of pulmonary congestion and edema, the arterial oxygen tension is usually only slightly lower than normal, but it may be very low in severe edema. However, there is no correlation between the clinical severity of left ventricular failure and the change in arterial blood gases. The hypoxia is presumably due to continued perfusion of non-ventilated areas of lung whose bronchioles are blocked by edema fluid (venous-admixture-like perfusion). When the work of breathing becomes exceptionally great, the hypoxia increases and carbon dioxide retention may develop.

In a recent survey of patients with myocardial infarction whose arterial blood gases were assessed while breathing room air, it was found that hypoxia was present in almost all patients.¹ Hyperventilation with a low pCO_2 was present in most cases, even if arterial oxygen tension was normal presumably because of an increased respiratory drive due to stiff lungs, while alveolar hypoventilation with a slightly elevated pCO_2 was present in a few patients. It was

also shown that the very low arterial pO_2 could not be attributed to a fall in cardiac output to one-half or one-third of normal but rather was due to continued perfusion of poorly ventilated areas of lung, a finding which was consistent with other investigators.^{2,3} Valentine, et. al.⁴ have shown that this venous admixture component was about three times normal immediately after myocardial infarction, the highest levels being reached on about the fourth day after infarction. Arterial gas tensions improved gradually after the second week following acute myocardial infarction, suggesting that pulmonary damage is sustained in the first few hours after the infarction and that it takes some while to recover, perhaps due to the very slow resolution of pulmonary edema.

Cardiogenic Shock

Although the cardiac output tends to be more severely reduced in the presence of cardiogenic shock, equally low values are found in some cases of myocardial infarction without shock. However, there is no overlap in stroke volume, and it would appear that cardiac output is maintained, at least in part, by an increase in heart rate in some of the shocked cases. This severe reduction in stroke volume, in the presence of an increased cardiopulmonary blood-volume, suggests serious impairment of left ventricular function. In addition, the systemic vascular resistance remains unchanged or only moderately increased in patients with cardiogenic shock. The absence of a reflex increase in peripheral vascular resistance to maintain blood pressure in the presence of a severe reduction in cardiac output suggests a grave disturbance of circulatory homeostatic mechanisms.

In patients with myocardial infarction who were in shock, or who had developed cardiac standstill and been resuscitated there was often severe hypoxia and in some cases the arterial pCO_2 was high¹ in addition to a metabolic acidosis. Once again the severe degree of hypoxia could not be explained by even a three-fold decrease in cardiac output. The findings in patients with cardiogenic shock or cardiac standstill complicating myocardial infarction was similar to that reported by MacKenzie, et. al.⁵ and indicates that a considerable proportion of the cardiac output was being

shunted through vessels inaccessible to pulmonary gas exchange.

Thus it appears that the pulmonary congestion of left ventricular failure, which is almost invariable in the shocked patient, is probably an important and common cause of the respiratory insufficiency following myocardial infarction. Nevertheless, clinical evidence of pulmonary edema may be absent in the presence of marked alterations in arterial blood gases. It seems that there may be widespread small areas of lung with collapse, blockage or flooding of alveoli with edema fluid, with continued circulation, which are not evident clinically.

Management

The demonstration of both severe respiratory insufficiency and metabolic acidosis in patients suffering from a myocardial infarction is of considerable therapeutic significance. These disturbances cause direct depression of myocardial function and a diminished pressor response to adrenaline and non-adrenaline and therefore might account for the disturbance of circulatory homeostatic mechanisms. In addition, ventricular fibrillation, which is the commonest cause of death after acute myocardial infarction, is most likely to occur in the first 48 hours, when the hypoxia is severe. The presence of severe hypoxia and acidosis may also account for the fact that the ventricular fibrillation following infarction, in contrast with that following procedures such as cardiac catheterization and intrathoracic surgery, is difficult to reverse. Early correction of metabolic acidosis and the hypoxia therefore might prevent ventricular fibrillation and result in improvement of mortality figures.

Correction of the acidosis should be achieved by careful titration of the required amount of bicarbonate administration against the arterial hydrogen ion determination. On the other hand, because of the large degree of venous admixture which is often present, correction of the hypoxia is more difficult. Administration of one hundred per cent oxygen is often necessary and in many instances even this may be inadequate to restore the oxygen tension to normal levels.

In addition to provision of adequate oxygenation, the management of the respira-

tory insufficiency in myocardial infarction should be based on the physiologic disturbances present,⁶ and should be designed to maintain an adequate alveolar ventilation and elimination of carbon dioxide, and to reduce the metabolism or the work of breathing.

Alveolar Ventilation

Patent Airway

In order to provide an adequate ventilation, it is essential to maintain a patent airway. In the comatose or semi-comatose individual it is usually necessary to instill an endotracheal tube. We have left an endotracheal tube in for as long as 10-14 days. Following this time a tracheostomy may be necessary. If a tracheostomy is performed it should be done over a bronchoscope, or if this is not possible, over the endotracheal tube. A rubber cuff which can be inflated should be placed around the tracheostomy tube so that respirations may be controlled if necessary.

Humidity

Under normal circumstances inspired air is at a temperature of 97° and is approximately 98% saturated with moisture when it reaches the bifurcation of the trachea. When air is breathed through an endotracheal or tracheotomy tube, the temperature and humidity is that of room air when it reaches the bifurcation of the trachea. Consequently the air takes up moisture in the bronchi, and the mucous membranes become dry and secretions tenacious. It is, therefore, essential to provide adequate humidity to the respiratory tract whenever an endotracheal tube or a tracheostomy tube is in position, for crusting and thickening of mucous develops unless the humidification is carefully attended to. This can usually be accomplished by the nebulization of oxygen or compressed air through heated saline or water into a perforated plastic adaptor placed securely over the tracheostomy opening.

Suctioning

Because of the frequent suctioning required by most patients with tracheostomies, there is nearly always some degree of tracheal trauma and infection. It is impor-

tant that the nursing staff be trained in absolute sterile technique as well as the performance of effective but gentle suction.

Suction should be carried out with a curved catheter, with only one opening at its tip, which is connected to a Y tube. The curve allows for easier passage into the left main bronchus. The single opening at the tip of the catheter is preferred since the tracheal mucosa may be damaged if a vacuum is exerted through side openings while the catheter is being withdrawn from the trachea, particularly if a plug is attached to the distal opening. A separate sterile catheter should be used each time the patient requires suctioning. The catheter should be inserted into the tracheo-bronchial tree for no longer than 10-15 seconds at a time and suction should be applied only during its withdrawal. As indicated by auscultation, the catheter should be directed into the right or left main bronchus as far as it will go, and then immediately withdrawn with a twisting motion. Too often, the catheter is pushed up and down the tracheo-bronchial tree, almost completely obstructing the airway for long periods of time.

Controlled Ventilation

If alveolar ventilation is inadequate as is evidenced by a high arterial $p\text{CO}_2$, it may be necessary to institute controlled ventilation.

Currently there are two basic principles in the operation of automatic respirators:

- 1) the controlled pressure respirator (eg. the Bird Respirator) in which the maximum airway pressure is adjusted by the operator to provide a suitable tidal volume, and,

- 2) the controlled volume respirator (eg. the Engstrom Respirator) which discharges a predetermined volume of gas during each inspiratory phase.

The force generated by any respirator during inspiration is expended against the resistance within the respirator, the resistance to flow in the tracheobronchial tree and the viscous and elastic resistances of lung and chest wall. If any of these resistances increase it will require more force to provide the same tidal volume. Conversely if the resistances decrease it will require less force to provide a given sized-breath.

So long as there is no change in resis-

NAME _____ I.C.U. BLOOD ANALYSIS

BLOOD GAS TENSION (mm. Hg)		ARTERIAL pH		Comments
pCO ₂	pO ₂	pH	pH	
130	350	7.50	7.50	
120	300	7.40	7.40	
110	250	7.30	7.30	
100	200	7.20	7.20	
90	150	7.10	7.10	
80	100	7.00	7.00	
70	50	6.90	6.90	
60	0	6.80	6.80	
50		6.70	6.70	
40		6.60	6.60	
30		6.50	6.50	
20		6.40	6.40	
10		6.30	6.30	
0		6.20	6.20	

W.G.H.
Form 525A-10-65

Fig. 1. Graphic monitor sheet used to record changes in arterial blood gases and pH.

Monitoring

Since the respirator is being used to provide an adequate alveolar ventilation, it is imperative to ensure that the arterial pCO₂ is maintained at normal levels. Ideally, therefore, the arterial or "rebreathing" pCO₂ should be monitored frequently and the respirator adjusted to maintain the pCO₂ at normal levels. Once an adequate alveolar ventilation is ensured, as evidenced by a normal arterial pCO₂, the respirator should be monitored at frequent intervals by observation of the airway pressure and tidal volume in a volume-controlled respirator; and by observation of the respiratory rate and, if possible, the tidal volume in the pressure-controlled respirator.

In addition, it is imperative to analyze the arterial pO₂. As long as the oxygen concentration of the inspired gas is constant, the arterial pO₂ is a sensitive indicator of minute pathological changes in the lung. A fall in arterial pO₂ frequently precedes clinical signs or x-ray findings by several days and should be taken to indicate the development of poorly or non-ventilated areas of lung which are still being perfused. The attending physician should then institute a vigorous effort to expand the lungs in order to open up small areas of atelectasis, and bronchoscopy to remove accumulated secretions may be necessary. The type of graphic monitor sheets which we use to record the changes in arterial blood gases and pH and the respiratory pattern and respirator delivery pressure are shown in Figs. 1 & 2. These monitoring sheets are extremely useful for they not only provide information about the situation existing at any one moment but also show trends which are indicative of minute pathologic changes in the respiratory system.

Although the current trend is towards the development of specialized "coronary care" units, it is apparent that the management of complicated myocardial infarction requires staff capable of recognition and management of respiratory insufficiency as well as circulatory failure. Similarly since diseases of other systems are often complicated by respiratory insufficiency we do not favor a unit utilized solely for patients suffering from acute respiratory failure.

Nevertheless there is a need for a spec-

tance to inflation, or leak in the airway, both the controlled pressure and controlled volume respirator will deliver a constant tidal volume. However, with the controlled pressure respirator, the amount of gas forced into the patient will fall reciprocally, if the resistance of the lung rises, because the pressure cutoff has been preset. On the other hand the controlled volume respirator will overcome an increase in resistance by delivering the tidal volume to the patient at a higher pressure.

Thus it is important to appreciate that a pressure-controlled ventilator will increase its frequency if the patient's resistance to inflation increases; will chatter in the face of complete obstruction; or hiss and fail to terminate inspiration if there is a leak in the airway. With a volume-controlled ventilator, on the other hand, increases in resistance to inflation or a leak in the airway will be reflected by changes in the airway or monitoring pressure.

alized unit for the management of all critically ill patients. Since the variety of diseases which may be complicated by respiratory failure, cardiac arrhythmias, circulatory collapse or fluid and severe acid-base imbalance conditions is wide, the patients may be scattered throughout the medical and surgical wards of a general hospital. When the management of these critical situations is carried out on the general ward on which they occur, there is often considerable chaos and frustration on the part of the attending personnel and lack of continuity in treatment. This is because of the divided responsibility of the nurses and residents on the general ward which is inseparable from such an arrangement. The added responsibility of caring for other patients of the general medical or surgical wards renders it virtually impossible for internes and nurses to devote sufficient attention to the minute details which often may make the difference between life and death. In addition, the constantly changing staff in the general wards renders it impossible to ensure sufficient background knowledge to provide the necessarily high quality of care which is required.

In our opinion, it is mandatory that these critically ill patients be concentrated in a special area where they can receive special attention and care directed at respiratory and cardiac malfunction and at maintenance of an adequate circulating blood volume and urinary output. The necessity for concentration of the care of the critically ill patient in a special ward area of a hospital is dictated by the overriding importance of a trained nursing and resident staff capable of understanding the equipment being used and the management of these patients. The unit must be organized in such a way as to be capable of recognition of all emergencies and be equipped to handle them for 24 hours/day. Unfortunately this standard of resident and nursing care cannot be achieved on every ward of a hospital.

In addition it is important to point out that the respiratory and circulatory failure seen in medical and surgical patients is the same. The establishment of separate medical and surgical units requires duplication of equipment and trained personnel, which in this day and age, is difficult to

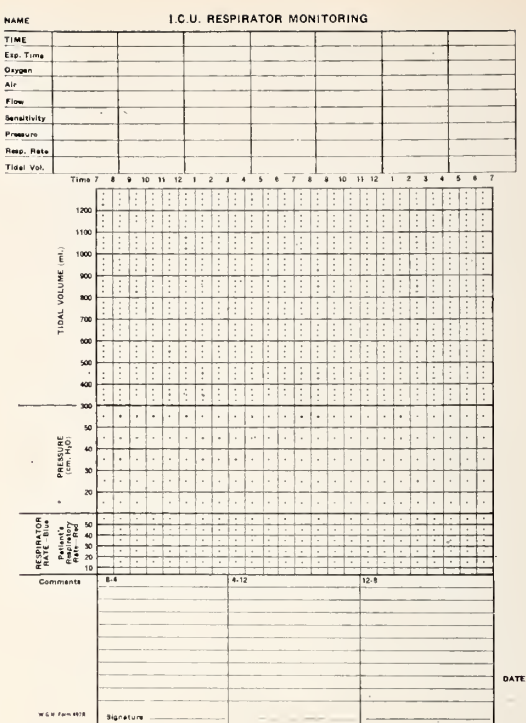


Fig. 2. Graphic monitor sheet used to record changes in respiratory pattern and respirator delivery pressure for patients on respirators.

obtain. Finally, by having the highly trained personnel and specialized equipment concentrated in one area, it is possible to initiate clinical investigation of disordered function in circulatory and respiratory insufficiency and shock, and the application of newer ideas in management.

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Progress in Otorhinolaryngology

BY JOHN R. LINDSAY, M.D./CHICAGO

It is only natural that the passage of time and the preoccupation with immediate health problems should dim the realization of the enormous achievements in medicine in recent years.

Prevention of disease, even though spectacular for a time, is soon accepted as a matter of course and the pre-existing condition forgotten.

Alleviation of disease may be more fully appreciated since the comparison of conditions before and after treatment may be more evident. The field of otolaryngology along with other areas of medicine has been profoundly influenced by certain basic discoveries. Perhaps the most fundamental of these came with the development of sulfonamide and antibiotic therapy for the control of bacterial infections. Several years before the sulfonamide therapy came into general use new possibilities for the investigation of hearing problems had already become available. The adaptation of discoveries in electronics and the use of behavioral responses in animal research opened up new methods for investigation of problems in communication and attracted the interest of basic scientists in several fields.

During the pre-antibiotic period histopathology of the ear was already pointing the way to refinements in surgery which have since culminated in modern surgery of the temporal bone.

Progress in the field of hearing in the past two decades includes also refinements in diagnostic hearing tests, new knowledge of causes for congenital deafness and the development of means for prevention of certain types.

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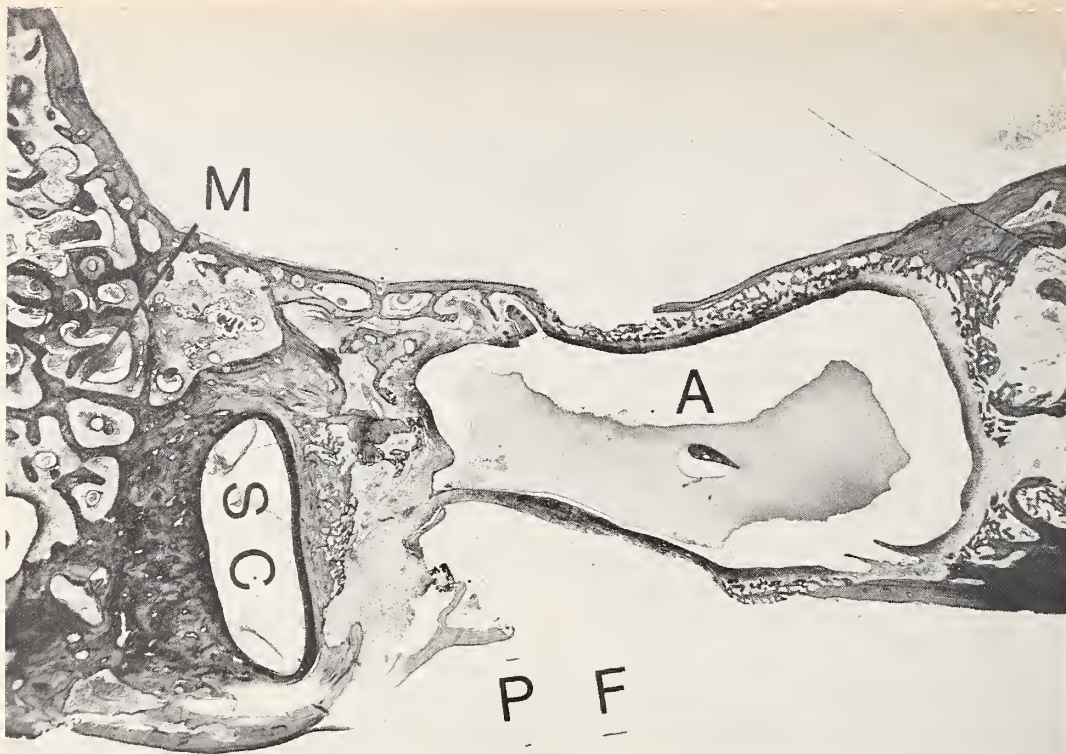


Fig. 1. Case S: Photomicrograph through superior border of petrous pyramid in a child with suppurative otitis media, petrousitis and meningitis. The coalescent abscess—A. The superior semicircular canal—S.C., forming the arcuate eminence separates the abscess from the mastoid cells—M. The area occupied by the abscess had been pneumatized from the epitympanum and mastoid. Posterior cranial fossa, P.F.

Suppurative Disease

Clinical otology in the first four decades of this century was primarily occupied with the problems of suppurative disease in the middle ear air cell system. Extension of the suppurative process to the inner ear, meningitis, brain abscess and invasion of the blood stream at that time frequently led to a fatal termination, despite thorough exenteration of the mastoid air cells.

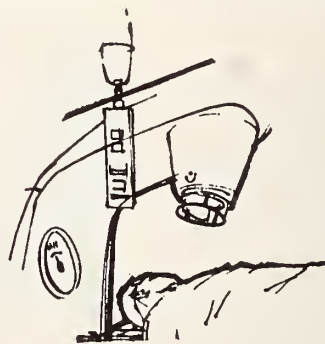
Detailed studies of the various patterns of pneumatization of the deeper parts of the petrous pyramid by means of serial sections and histopathological studies in fatal cases gradually provided a key to the problem. Extension of suppuration into deeper parts of the pyramid was found to follow along air cell tracts. The tracts developed in certain patterns varying from case to case and usually led through a narrow neck to an expanded area in the perilyabyrinthine or apical part of the pyramid.

Blockage of the entrance pathway by inflammatory swelling led to abscess formation, absorption of bony cell partitions, a coalescent osteitis, localized osteomyelitis and eventually extension to the inner ear, the meninges, the brain or into large venous sinuses.

Osteomyelitis of the apical part of the petrous pyramid, formerly thought by many to be of hematogenous origin was found usually to develop from invasion along an extension of air cells into the marrow containing apex. Formulation of a coalescent abscess included surrounding bone marrow.

Knowledge of the patterns of pneumatization provided the key to clinical symptomatology and the x-ray interpretation which usually indicated the surgical ap-

Medical Progress



HARVEY KRAVITZ, M.D.
Medical Progress Editor

proach by which the abscess could be drained without damaging the inner ear.

Results were increasingly successful provided that surgical drainage was carried out before the infecting organisms had been disseminated intracranially.

The development of sulfonamide and later antibiotic therapy provided a means of controlling most of these bacterial infections at the onset. When the antibiotic was appropriately selected and adequately used from the onset the need for surgery was reduced to a minimum. However, when a coalescent abscess had already formed either because of lack of treatment, an insensitive organism, or inadequate therapy, it was sometimes found that the relief of all symptoms only meant that the abscess had been temporarily walled off.

A sudden breakdown of such a focus with sudden and rapidly fatal meningitis sometimes occurred after weeks, months, or even a year following apparent cure of a suppurating petrous apicitis (Fig. 1 & 2) or a diffuse suppurative labyrinthitis which had become quiescent but still latent.

Fortunately the occurrence of complications from acute suppurative ear disease

in areas where competent medical care is provided is now relatively rare but the physician and otologist must still be alert to the possibilities.

The otologic surgeon still requires knowledge of the problem of suppuration in the petrous pyramid and the interpretation of x-rays in order to recognize and deal with persistent foci without destroying the inner ear.

The development of antibiotic therapy has not only provided the means of saving lives and reducing the need for surgery for acute suppurative disease but has contributed greatly to the prevention of deafness. Injury to the conduction mechanism and to the inner ear was reduced, and one of the main causes of deaf-mutism, meningogenic labyrinthitis due to the meningococcus, was brought under better control.

Microsurgery of the Ear

Chronic progressive conduction deafness beginning about puberty or in early adult life has been known since late in the 19th Century to be due to a localized bone disease, called otosclerosis, which caused



Fig. 2. Case S: Photomicrograph at a lower level than Fig. 1. The abscess-A, has eroded the posterior surface of the pyramid between the superior semicircular canal and the internal auditory meatus -I.M. Pus cells have infiltrated the meninges. The middle ear-M.E., and mastoid cells contain pus and inflamed mucosa.

bony fixation of the stapes in the oval window. Histopathologic studies have shown an incidence of the disease of about 15% in the Caucasian race although stapes fixation occurred in a much smaller number. Attempts to restore movement of the stapes or to create a new window to permit sound to enter the inner ear had met with only temporary success and were apparently discouraged because of unfavorable results at about the turn of the century. Further efforts were continued, however, by a few surgeons, notably Holmgren of Stockholm, who tried several methods of making a new window into the labyrinth. Results reported by Holmgren in 1930 were encouraging but subsequent osteogenic closure of the new window and loss of the hearing gain within a few months remained an unsolved problem. Stimulated by Holmgren's work, the French ear surgeon, Sourdille, devised a two-stage procedure which was successful in creating a permanent new window in the horizontal semicircular canal, covered by the skin lining a radical mastoid cavity. The fixed stapes was by-passed and the tympanic membrane left in place, thereby protecting the round window from the sound pressure, to which the new window was directly exposed.

Sourdille's procedure was further developed by Lempert, of New York, into a one-stage operation which he reported in 1938 and subsequently became known as the "Fenestration Operation."

The fenestration procedure, part of which was carried out with the aid of a magnifying loop, required training and skill well beyond conventional mastoid surgery. It was taken up by a limited number of otologists, mainly in the Americas and Europe, since the disease was not



Fig. 3. Case K: Photomicrograph showing a chronic abscess in the petrous apex, labyrinthitis, sequestration and rupture into the internal auditory meatus. Death from fulminating meningitis one year after an apparent cure of acute middle ear suppuration under Sulfonamide therapy.

**Abscess in petrous Apex, A.
Internal Carotid, I.C.
Sequestra, S.
Middle Ear, M.E.
Internal Meatus, I.M.**

known to be prevalent in the non-caucasian races. The operation was successful in restoring hearing to a practical social level without the use of a hearing aid in cases where the neurosensory apparatus was in good condition (Fig. 3 & 4). A handicap of about 25 db was unavoidable since the normal sound conduction mechanism was no longer functioning.

The operation gave satisfactory and permanent results in the majority of suitably selected cases. However, in about one third of otosclerosis cases the degree of superimposed sensorineural impairment was sufficient to preclude adequate improvement by this means.

In 1952 the possibility of mobilizing the fixed stapes and maintaining the action of the conducting mechanism was rediscovered by Rosen of New York. The procedure had been used some 50 years earlier, by operating through the drum membrane but had been given up, apparently because of lack of good results and risk to the inner ear.

Rosen used Lempert's method of exposing the middle ear through the external canal by elevating a flap of canal skin and the eardrum. This permitted mobilization

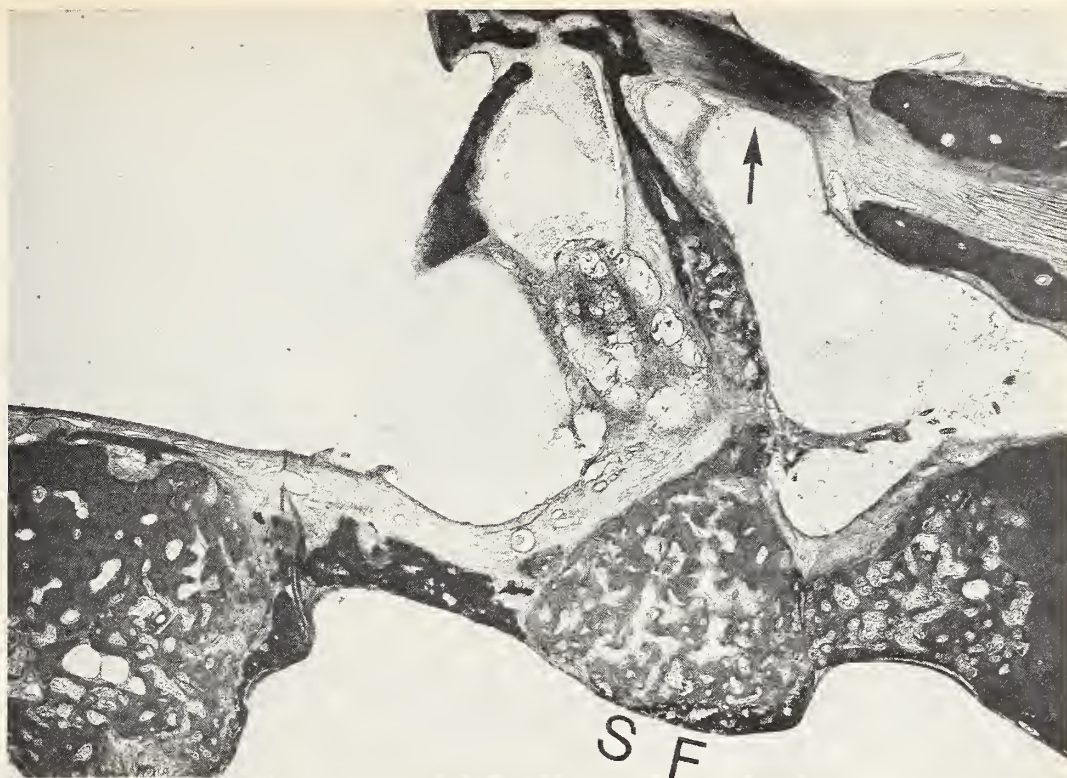


Fig. 4. Case MeN: Photomicrograph showing otosclerosis of the rim of the oval window and the stapes footplate-S.F., and posterior crus with stapes ankylosis. The attachment of stapedius tendon to the head of the stapes is visible (arrow).

of the stapes in some cases, after which the drum was replaced.

The advantage of a procedure which would restore the function of the conducting mechanism was quickly recognized. The avoidance of after care and the simplicity of the procedure also offered a distinct advantage to both patient and surgeon. Simple mobilization was soon found to be impossible in many cases, and temporary in the majority of others, because of re-fixation of the stapes. Further developments led to the removal of the diseased stapes totally or in part. Restoration of a functioning chain has been accomplished by a variety of methods, depending partly on the extent of the otosclerotic focus. The most frequently used method has been the application of a graft to the oval window. Vein, connective tissue, fat or a plaque of gelfoam are currently most favored and are connected to the incus by a fine wire (Fig. 5). Success in restoring the sound conduction mechanism has been reported in about 75%. Complications have been infrequent and maintenance of a functioning conducting mechanism has been satisfactory in all but a few up to the present.

An important factor in the development of fenestration and stapes surgery was the perfection of the binocular operating microscope, an instrument permitting free movement into all positions, magnifications up to X40, good lighting and ample working distance. This instrument has made microsurgery of the ear possible and has become standard equipment in ENT operating rooms and in otological research laboratories.

Recent developments in microsurgery of the ear have included repair or replacement of the tympanic membrane and repair of ossicular defects due to disease, congenital anomalies and dislocations.

Modern microsurgery of the ear has also made possible the removal of small tumors of the eighth nerve located deep in the internal meatus.

The trans-temporal and trans-labyrinthine surgical approaches pioneered by William House have stimulated early diagnosis and demonstrated the feasibility of complete removal of small tumors or removal of the portion of tumor located deep in the meatus as part of a combined translabyrinthine and posterior fossa approach.

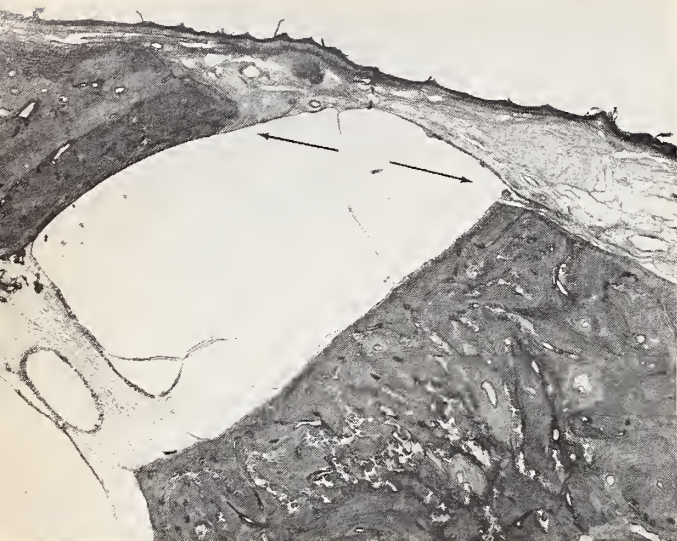


Fig. 5. Case McN: Photomicrograph showing the surgically created fenestra in the horizontal semicircular canal (arrow) covered by a skin flap from the posterior canal wall. The ankylosis of the stapes is shown in Fig. 4. Hearing was restored to the practical level by the procedure. (Operation by Dr. Keeler of Oakland, California).

Medical Audiology

While the most fundamental and even dramatic changes in the field of otology have been the result of anti-bacterial drugs and the development of microsurgery of the ear, significant developments have taken place in the field of hearing and communication and in investigation of the vestibular system. New and important aids to the diagnosis of hearing problems have resulted from the basic investigations conducted by otologists, bio-psychologists, physicists, electronics engineers and audiologists. Schools have been established for the training of specialists in speech and audiology.

Medical audiology which contributes the special skills required for evaluation of hearing and hearing aids in the various age groups has become an important part of the modern otological department or office.

Inner Ear Histopathology

The study of histopathological changes in the inner ear associated with loss of hearing and equilibrium has expanded greatly in the past decade. Due to the difficulty in obtaining the documented pathologic temporal bone specimens containing the middle and inner ear and the laboratory expense involved in processing them, very few training programs in the Americas included such a facility previous

to the last decade. In recent years the efforts of the Deafness Research Foundation in informing the general public and particularly the deaf of the need for specimens have been increasingly successful in promoting cooperation in the way of pledges of temporal bones for research purposes.

Through the support of the Deafness Research Foundation the otological profession and the National Institutes of Health, histopathological laboratories are now in operation in about 40 of the otolaryngology training programs. They are used both for research purposes and training in histopathology, as well as surgery of the ear.

Studies of histopathology have contributed steadily to knowledge of pathways of infection in the temporal bone and the understanding of deafness due to virus infections, Meniere's disease, drugs, high-level noise, genetically determined disorders, and other less frequent diseases affecting hearing and equilibrium.

Vestibular Research

The vestibular system has been under special investigation for many years from a clinical viewpoint because of the frequency of vertigo and disorders of equilibrium, and its frequent involvement in disorders in the posterior cranial fossa.

In recent years, investigation has been stimulated by an increase in vertigo and disorientation in space experienced by pilots of high speed jet planes, and also by the necessity to anticipate and avoid problems of equilibrium in the weightless state in outer space travel.

Unfortunately, when the sensory receptors in the inner ear have been destroyed either partially or totally, regeneration does not occur. Hearing may be aided in certain instances by amplification but the capacity of the ear cannot be restored. Reduction of the incidence of disabling sensorineural deafness depends therefore upon prevention of the causative factors.

Prevention of Deafness

Hereditary disorders of the auditory system, occurring in both fetal and in later life, still constitute an unsolved problem.

Certain causes for acquired profound deafness in all stages of fetal life and in early "childhood" have recently been iden-

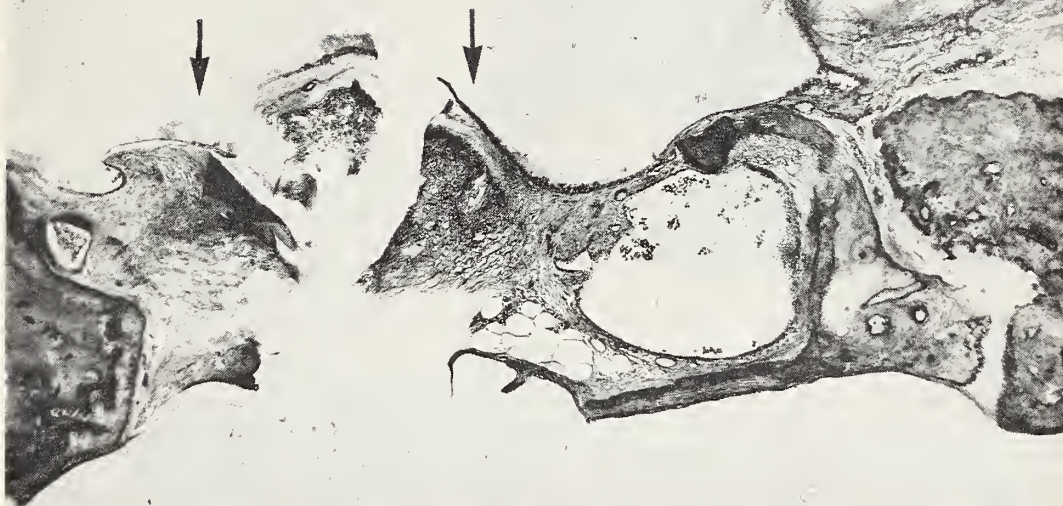


Fig. 6. Case II.: Photomicrograph of the oval window in a case of ankylosis of the stapes byotosclerosis. Part of the footplate was removed and replaced by a vein plug attached by wire to the incus. (arrows) The defect in the graft indicates where the wire had been attached to the graft and removed to permit sectioning. Hearing was restored to a nearly normal level. (Operation by Dr. Howard House).

tified and can now be prevented. Maternal rubella in the early months of pregnancy, now known to be a common cause of profound damage to the auditory sense organ, as well as other disorders, should soon be eliminated either by exposure of females to the disease or by the use of recently developed vaccine. The virus of measles (rubeola) which has been reported to account for from 1% to 5% of deaf-mutism also should be prevented by the available vaccines.

Progress is developing in the prevention of fetal damage from Rh incompatibility. Other causes of congenital deafness including anoxia and ototoxic drugs have been identified and the necessity for avoidance stressed.

Certain types of progressive sensorineural deafness such as presbycusis, Meniere's disease and advanced otosclerosis are the most common causes for hearing disability in late adult life. The etiology of these has so far not been found, although investigations have contributed considerable information bearing on pathogenesis.

Rhinology and Laryngology

Progress in the ENT field has not been limited to otology. Rhinology has been influenced greatly by antibiotic therapy, but

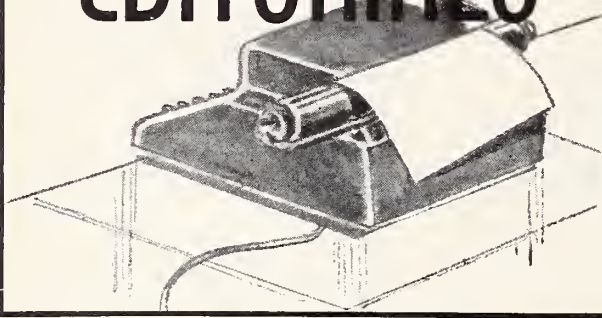
with the decreases in complications of infections such as osteomyelitis, there have been improvements in surgery for tumors, facial trauma, nasal deformities, hypophysectomy and in the medical care of the upper airway.

Laryngology has experienced improvements both in diagnosis and in surgery. The development of direct laryngoscopy and bronchoscopy has been extended to mediastinoscopy in many institutions.

Surgery for laryngeal and pharyngeal problems including malignancy has developed rapidly in recent years. Several factors have contributed, including advances in anesthesiology, pre- and post-operative patient care and radiation therapy. The most significant factor has been the improvement in training in most ENT training programs and the inclusion of the neck surgery necessary as a part of surgical care of laryngeal and pharyngeal problems.

The advances which have taken place in technology in recent years have included many developments in the general field of communication. The basic dependence of communication upon the special senses has accentuated interest and investigation in the field of hearing, equilibrium and voice production. ◀

EDITORIALS



AMBULANCE DRIVERS AND ACCIDENTS

In 800 California highway accidents, 90 per cent of those injured in rural areas died at the scene of the crash within an hour. In contrast, only 37 per cent of those injured in urban areas died before the ambulance arrived. This emphasizes the fact that prompt emergency care is available in cities, but not always in the country. To this we must add that 70 per cent of the 54,000 traffic deaths occurred in rural areas last year.

Many physicians know that more lives could be saved if the victims reached the emergency room sooner. In addition, they must be transported safely and without aggravating existing trauma. Interest in this aspect is growing. The Committee on Trauma of the American College of Surgeons has many subcommittees throughout the country working on the problem. The American Association of Automotive Medicine and Physicians for Automotive Safety also have been active in this field.

We must train more ambulance drivers and helpers to remove the victims without aggravating fractures and internal injuries. This can only be done through formal courses in first aid conducted by physicians interested in controlling death on the highway. Ambulance personnel must be taught to recognize fractures and learn how to

handle splints. They must be able to recognize shock and to control bleeding. Obstructed airways are a major cause of death and the ambulance crew must be able to perform emergency measures if some of these people are to be saved.

Proper equipment also will be needed. Improved communications between ambulance and emergency room are essential. A member of the ambulance crew should be able to talk to the person in charge of the emergency room, not so much for advice, but to alert him as to when they are arriving and what to expect.

Communities benefit from modern ambulance service. Vehicular injuries occur at the rate of 10,000 per day. This is 50 or more times the Viet Nam casualty rate. All other accident causes account for another 60,000 fatalities annually. In many communities, the ambulance service is run by the local undertaker and his staff has little or no training in emergency measures.

Hospital emergency rooms should be updated to cope with the increasing incidence of accidents. Some areas have trauma centers supervised by physicians who specialize in this type of care. The emergency room must be properly equipped with alert, well-trained, and responsible professionals.

T. R. Van Dellen, M.D.

SUBMUCOUS CLEFT PALATE— A CONTRAINDICATION FOR TONSILLECTOMY AND ADENOIDECTOMY

Although the submucous cleft palate has been recognized for over 125 years, it is still a commonly missed diagnosis. A study

of this condition was reported in the Archives of Otolaryngology by Tholer and Smith, who emphasized the need for early

diagnosis and treatment of submucous cleft palate. They warn that performing T & A on these patients may result in a permanent type of nasal speech seen in patients with true cleft palate.

Submucous cleft palates can and should be looked for in every newborn infant. The condition is characterized by a short wide uvula. The palate often is short and stiff and hangs vertically like a curtain. Some cases have bifid uvulas. The midline of the palate may be very thin or even have a very small perforation or can be without a muscular component. The bony palate may have a slight midline notch along the posterior border or may be ab-

sent in a long narrow V-shaped area up to the anterior alveular ridge. Clinically, there may be no symptoms but suspicion should be aroused by regurgitation of solid and liquid foods and hypernasal speech.

Unfortunately, the removal of the tonsils and adenoids make an effective, functional repair of a submucous cleft palate a more difficult procedure. The authors emphasize that T & A should not be done in these cases and that the submucous cleft palate be first repaired by removing the epithelial web and re-uniting the muscular elements of the palate.

Harvey Kravitz, M.D.

THE EARLY DRUG STORE

History tends to repeat itself. At one time English apothecaries were a part of the Grocers' Company. Although the groups separated 350 years ago, both celebrate the event annually. Some of our modern drug stores also sell groceries, and supermarkets do a thriving drug business.

Originally, apothecaries were associated with pepperers and spicers. Some were wholesale merchants, others shopkeepers or dispensers of drugs. They did not restrict themselves to the sale of medicines. Spicerers were connected with the spice trade in any capacity. Pepperers were primarily wholesale merchants and shippers whereas spicers were concerned mainly with retail sales. The pepperers became the Grossarii or weighers and were in charge of the Great and Small Beam, official standards for weighing.

Guild records first included the title grocer in 1373. The term came probably from a merchant named Grosser or from their descriptive title. Apparently the group was organized mainly by spicers and pepperers who adopted the title of the Grocers' Company. Apothecaries maintained their identity in the organization, explaining why a considerable number of the Grocers' Company kept apothecaries' shops. The 13th and 14th century apothecaries also sold castile soap, sponges, wines, cotton, wool, pots from Geneva, leather bags, cloth, silver

spoons, and lead in bulk (Charlie Walgreen, please note.) It is evident that extensive inventories in pharmacies have a long history.

Richard Weston was the first hospital pharmacist. He was affiliated with St. Bartholomew's Hospital (London) in 1571.

T. R. Van Dellen, M.D.

References

T. D. Whittet. "Pepperers, Spicerers and Grocers—Forerunners of the Apothecaries," *Proc. Soc. Biol. & Med.* (Aug.) 1968, pgs. 801-806.

MAN OF THE YEAR

On Wednesday evening, April 30, a testimonial banquet was held to honor Harvey Kravitz, M.D., as Man of the Year in Chicago Medicine. The honor was bestowed by the Physicians Division, State of Israel Bonds.

Dr. Kravitz, since receiving his M.D. from the University of Illinois in 1944, has practiced in Pediatrics in Chicago. In addition to his practice, he is very active in many activities of professional medicine. He currently serves as Medical Progress Editor of this journal.

The selection committee has made a good choice; we join to extend our congratulations to Dr. Kravitz on his being selected.

The *IMJ* Staff

Illinois' personal income in 1966 exceeded \$38 billion. Its per capita income was \$3,532, highest among the 10 largest states.

Illinois leads in the total production of doctorate degrees among the states in the Great Lakes region.



THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Diagnostic Radiology, Cook County Hospital,
and Clinical Professor of Radiology, Chicago Medical School*

This 40 year old Negro male entered Cook County Hospital approximately ten hours after onset of symptoms. He awakened with his abdomen feeling "tight." He felt his abdomen becoming more distended and then nausea and vomiting ensued.

Physical examination: Patient appeared acutely ill. Tenderness was present in both lower abdominal quadrants without rebound. Bowel sounds were absent and the rectum was empty.



Fig. 1

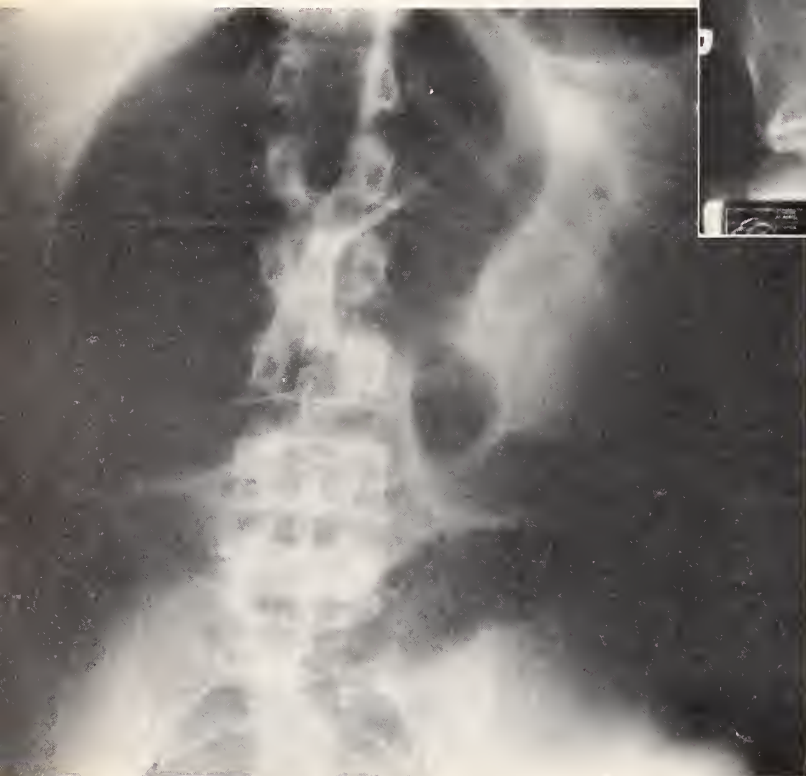
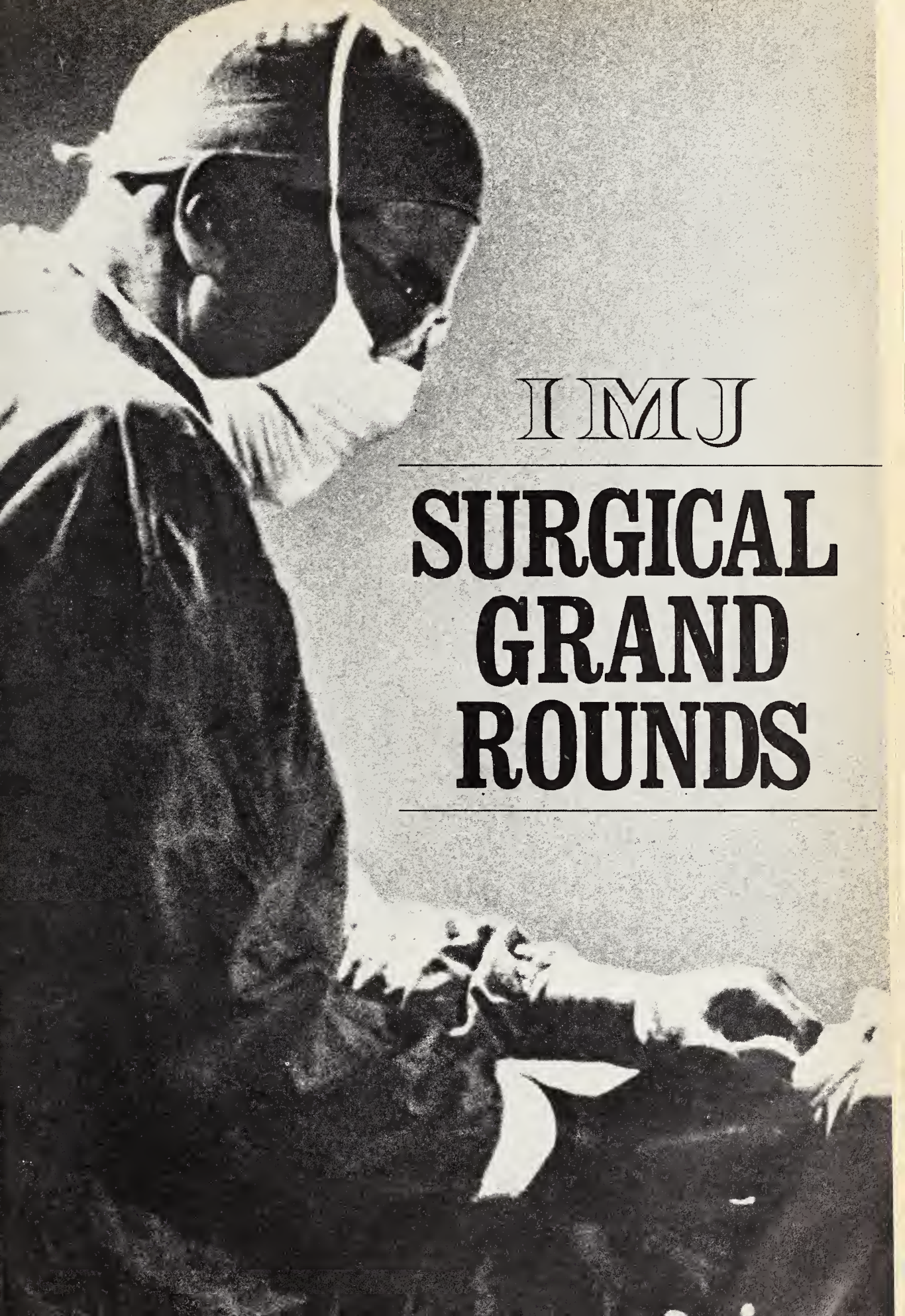


Fig. 2

What's your diagnosis?

- 1) Sigmoid volvulus.
- 2) Cecal volvulus.
- 3) Intestinal knot syndrome.
- 4) Gas peritonitis.

(Answer on Page 642)



I M J

**SURGICAL
GRAND
ROUNDS**

Surgical Grand Rounds are held weekly on Saturday at 8:00 A.M.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on September 21, 1968.

Snake Bite

CASE PRESENTATION:

Dr. Ralph Otto: The patient is a 26 year old white male who was bitten on the dorsum of his right hand by a ten inch long Australian Death Adder. Approximately 45 minutes after the bite, he first noted generalized numbness and tingling followed by shortness of breath. Because the patient is an amateur snake handler he kept a box of assorted antivenins in his home, and this was brought with him to the nearest hospital emergency room. Upon arriving at the hospital, and before identifying the snake which had bitten him, the patient became apneic and lost consciousness. He was placed on a Bennett respirator, and a venous tourniquet was applied to the right upper arm. An intravenous infusion was started, and the patient was given 500 mgm. of hydrocortisone intravenously because he had a past history of allergy to horse serum. The only antivenin brought by the patient which was effective against neurotic snake venom was Taipan antivenin, and one and one-half ampules were administered intravenously. The patient regained consciousness and was able to identify the snake as an Australian Death Adder. The right hand was prepped and an ellipse of skin and subcutaneous tissue one inch around the fang marks was infiltrated with one per cent xylocaine and excised. The open wound was irrigated with two liters of Ringer's lactate solution, and a sterile dressing and splint were applied.

Ice packs were then placed over the hand and forearm. Approximately one hour after the patient arrived in the emergency room type specific Death Adder antivenin was obtained. The patient was still dyspneic and required respiratory assistance, but after the intravenous injection of 6,000 units of specific antivenin his dyspnea improved and the numbness and tingling disappeared. However, when the tourniquet was removed, symptoms returned requiring an additional 3,000 units of antivenin. After two similar attempts the tourniquet was removed without return of symptoms, and the patient was transferred to Passavant Hospital. However, about 20 minutes after arrival at Passavant he again developed dyspnea and numbness and tingling throughout his body. He was given a total of 24,000 units of specific antivenin, the last at 1:30 A.M. yesterday. Since that time he has remained asymptomatic. The patient was also given tetanus toxoid, streptomycin, and intravenous penicillin.

Laboratory studies performed on admission revealed a hematocrit of 45%, a white blood count of 6,000 cells per cu. mm. with a normal differential count, a prothrombin time of 75% of the control, and a normal urinalysis. Subsequently, the only change in his laboratory values has been a decrease in his hematocrit to 41%. Examinations of the urine and plasma have been negative for free hemoglobin.

Table I
PATHOLOGIC EFFECTS OF SNAKE VENOM

Family	Neurotoxic	Hemotoxic	Coagulant
			Anticoagulant
Crotalidae	+	++	++++
Elapidae	++++	+++	++
Viperidae	+	+++	++++
Colubridae	+	+	++++

Patient enters in wheelchair:

Dr. Stuart Poticha: Would you describe how you felt when you knew the venom was taking effect?

Patient: There was little pain in the hand. If I hadn't seen the snake bite, I wouldn't have realized that I had been bitten. The first thing I noticed was an irritation or semi-soreness of the throat, and I became very apprehensive. I had very little physical discomfort.

Dr. Poticha: Did you have any trouble breathing?

Patient: Yes, I had trouble breathing on the way to the hospital. I don't remember the trip to the hospital very well.

Question from audience: Was this a full grown snake that bit you?

Patient: Probably not. It was a two-fang bite from a ten inch snake, but I think it was still just a large baby. They don't get very long but they get heavy-bodied.

Question: Did you give yourself any first aid treatment before you went to the hospital?

Patient: No, I took the serum that I had to the hospital but I didn't do anything myself.

Dr. Poticha: The patient has been bitten before by a snake from a different family. Would you tell us about that episode? The symptoms were quite different.

Patient: I was working behind a hedge and was bitten by a full grown water moccasin, at least four feet long and very heavy bodied. He bit me with just one fang and he barely made an incision. You couldn't make as small an incision if you were working with a razor blade. By the time I turned around, my hand had covered a whole wall with blood. It bled just as soon as the snake touched it. I sat down in the kitchen. We had serum on hand, but I

didn't take any because I thought it was just a minor scratch. Within three minutes the pain was unbearable, like holding your hand over an open fire. This was a most painful bite, although I didn't think there had been much damage done. I had a watch on and by 20 minutes after the bite I couldn't slide the watch over my hand.

Dr. Poticha: Inspection of his left index finger demonstrates a tremendous amount of soft tissue damage. There is atrophy of the soft tissue with only skin and bone remaining in the distal phalanx. The damage and the symptoms are typical of a bite from this family of snakes.

Question: How do you happen to have contact with snakes? Is this a hobby or do you work?

Patient: It is a hobby, but I often donate snakes to the zoo. When I was in South America I sent back some snakes to them, but I have not been paid for any work I have ever done with snakes. I am a salesman.

Dr. Poticha: Snake bite is a rather ominous problem in the world, although relatively uncommon in the United States. There are approximately 30,000 to 40,000 deaths per year from poisonous snake bites in the world, of which 25,000 occur in Southeast Asia. In the United States there are 6,000 to 7,000 venomous snake bites with 15 to 20 deaths per year.

Four families of venomous land snakes are distributed throughout the world: Elapidae, Viperidae, Crotalidae, and Colubridae. There are four types of venomous snakes indigenous to the United States. Rattlesnakes, moccasins, and copperheads belong to the family Crotalidae and coral snakes belong to the family Elapidae. Each family produces a venom of slightly different characteristics (Table I).

Snake venom consists of a group of complex protein enzymes which are divided into three broad categories depending on the action they exert. Neurotoxic venom contains phospholipase a, and related enzymes which injure nerves interfering with conduction. Hemotoxic venoms cause profound lysis of red blood cells, producing anemia, hemoglobinemia, hemoglobinuria, and occasionally renal failure. Coagulant/anticoagulant venoms cause extensive systemic hemorrhages as well as bleeding and profound tissue necrosis at the site of the bite.

The snake which bit this patient, an Australian Death Adder, belongs to the family Elapidae. This family contains such species as the cobras, mambas, and the North American Coral Snake. The venom of these snakes is primarily neurotoxic, and a bite by one of these snakes characteristically produces the symptoms described by this patient: dryness in the throat, numbness and tingling, blurred vision, and finally dyspnea, loss of consciousness, and respiratory arrest.

The family Crotalidae contains the pit vipers such as the North American rattlesnakes, moccasins, and copperheads. Their venom consists mainly of coagulant and anticoagulant enzymes. The major symptoms produced by envenomization are excruciating pain and hemorrhage at the site of the bite. Systemic hemorrhages may also occur. Extensive necrosis and loss of the soft tissues surrounding the bite is common. This patient's description of his bite by a moccasin is characteristic of pit viper envenomization.

The family Viperidae contains the European and Asian true vipers. Their venoms contain large amounts of both hemotoxic and coagulant/anticoagulant enzymes. Patients bitten by these snakes usually present with hematemesis, melena, and hematuria. Renal shutdown secondary to hemoglobinemia is common.

The family Colubridae is characterized by snakes whose fangs are located at the rear of their upper jaws. The fangs are swung forward as the snake strikes. The African Boomslang and Bird Snake belong to this family, and although little is known about these snakes, it is thought that their venoms consist mainly of coagulant/anticoagulant enzymes.

The mainstays in the treatment of veno-

mous snake bite are: 1—administration of specific antivenin, 2—tetanus prophylaxis, and 3—administration of broad spectrum antibiotics. Although authorities unanimously agree on the importance of these principles, there is disagreement about the efficacy of the following additional measures used in the treatment of poisonous snake bite: 1—application of a tourniquet, 2—cooling of the affected extremity, 3—surgical treatment of the bite and 4—administration of corticosteroids.

The use of a tourniquet has been recommended in cases of envenomization by Crotalids, if it can be applied within 30 minutes of the injury. However, the use of a tourniquet was very effective in this patient even though it was applied 45 minutes after a bite by an Elapid snake. I gave the patient a dose of antivenin, and he regained consciousness, and was able to breathe unassisted. I then removed the tourniquet and he immediately began to get numbness and tingling again and then became dyspneic. The tourniquet should not occlude the arterial circulation. The same kind of tourniquet a lab technician uses to occlude the superficial venous circulation is all that is needed since most of the venom drains through the superficial veins and lymphatics. It is wrong to repeatedly take the tourniquet off and then reapply it because it has been shown that this technique pumps more venom into the patient. If specific antivenin can be obtained within two hours, the venous tourniquet should be left in place until the antivenin is administered.

In 1958 Stahke recommended that when envenomization occurs in an extremity, the limb should be immersed in fresh water ice for several days. Such treatment would appear to add the danger of frost bite to an extremity whose vascularity has already been compromised. The United States Naval manual, *Poisonous Snakes of the World*, condemns this therapy. A short period of cooling the affected extremity to further retard venom absorption may be advantageous and should be used until the antivenin is administered.

Incision and suction is the classical method of surgical management of the wound. This is most effective in treating bites of North American Crotalid snakes. Experiments have shown that incision and suction can remove up to 53% of the in-

jected venom. One should remember that a snake fang is curved. The incision should be made in the direction of the curve so that subcutaneous tissue and muscle surrounding the tract can be opened. Experimentally, excision of the skin and subcutaneous tissue for one inch surrounding the bite can remove as much as 79% of the injected venom when performed within ten minutes of the injury. Excision of the wound is treatment of choice when it can be performed in the hospital by a physician using sterile technique who will not injure nerves or tendon. Of course, excision is contraindicated in bites of the digits or palm of the hand. The wound was excised in this patient.

The use of corticosteroids is probably of little value in specifically counteracting venoms. However, since snake antivenin is produced from horse serum, corticosteroids may prevent or decrease the severity of allergic reactions. It is advisable to skin test the patient before administering the antivenin, and if the patient is found to be sensitive, desensitization should be undertaken. Desensitization is a time consuming procedure, and in a case such as this where the patient is already experiencing respiratory difficulty, the rapid administration of antivenin may be life saving. The Queen Saovabha Memorial Institute in Bangkok, Thailand, manufactures many

of the Elapid antivenins. Cobra bites are common in Bangkok and most of these patients are treated in this institution. They recommend large intravenous doses of corticosteroids, followed by antivenin without skin testing in cases of serious envenomization by Elapid snakes. This technique was used successfully in this patient.

Although a patient improves following the administration of specific antivenin, he must be carefully observed for 48 hours. As was demonstrated so dramatically in this patient the initial improvement may be temporary, and as more venom is released into the systemic circulation the symptoms can reoccur requiring additional antivenin. During this period of observation one should obtain serially the following laboratory tests: CBC, BUN, Urinalysis, plasma and urine for free hemoglobin, prothrombin time, coagulation time, EKG, and serum electrolytes.

Question: When do you plan to close the wound?

Dr. Poticha: A delayed primary closure is planned at five days if the wound is clean and granulating well. I inspected the wound yesterday. It appears that the venom of this snake is purely neurotoxic, since there is no evidence of necrosis at the wound edge, and the patient has not developed hemorrhages or hemolysis.

Erythromycin Effective Against Viridans

For victims of heart valve damage caused by rheumatic fever, a trip to the dentist can mean death.

A Northwestern University medical researcher, Dr. Philip Y. Paterson, however, reported that therapy involving a standard antibiotic, erythromycin, is a highly successful preventative of these ominous consequences.

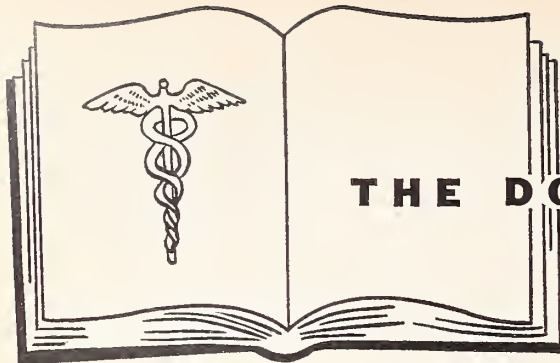
Everyone carries an organism called viridans streptococci in his mouth. In the process of drilling or other dental work, the organism is released into the bloodstream. This causes no consequences in normal persons. In their route through the bloodstream of the rheumatic fever victim, however, viridans shows an affinity for lodging in heart valves.

This can cause the often-fatal disease of

bacterial endocarditis. In 1965, for example, some 15,000 persons died in this country from rheumatic disease connected with valvular defects and complications.

The traditional means for protecting rheumatic fever victims from the consequences of a visit to the dentist has been inoculation with penicillin. Unfortunately, since many rheumatic fever sufferers also receive penicillin for control of other aspects of the malady, they are likely to have developed a penicillin-resistant strain of viridans.

Dr. Paterson reported on the results of giving 53 rheumatic heart victims a type of antibiotic known as erythromycin estolate. In 50 of these persons, erythromycin wiped out "enormous numbers" of penicillin-resistant viridans, he said.



THE DOCTOR'S LIBRARY

ORR'S OPERATIONS OF GENERAL SURGERY.

George A. Higgins, M.D., F.A.C.S., 4th Edition, W.B. Saunders Co., Philadelphia, 1968.

The basic essentials of techniques in general surgery, cardiovascular surgery, orthopedics, urology and gynecology are covered in the current revision of *Orr's Operations of General Surgery*. The broad coverage of surgical subjects should appeal to students, interns, and residents searching for a starting point in their reading about "how to do it" as they contemplate observing or performing surgical procedures. Practicing surgeons will find the text useful as they review the care of their patients and prepare for an operation.

Fundamentals of wound healing and wound management are emphasized in the initial chapters. The proper type and location of incisions and the choice of suture materials are also stressed. These chapters should have universal appeal to physicians practicing surgery regardless of their specialty.

Having reviewed the essentials of good surgical practice, the authors highlight, step by step, the techniques of many commonly performed operative procedures. Numerous illustrations are used to clarify the descriptions of the operations. Alternate techniques are frequently mentioned and references are presented so as to enable the reader to augment the material in each chapter as necessary. Methods of preventing and avoiding complications are described as the details of performing the various operations are presented.

The appeal of this textbook of surgical techniques is broad. Readers will find many old and many new facts presented clearly and concisely and, as a result, will remove the book from the shelf frequently.

Julius Conn, Jr., M.D.

ATLAS OF PRECAUTIONARY MEASURES IN GENERAL SURGERY.

Ivan D. Baronofsky, The C. V. Mosby Company, 281 pages, 1968.

This atlas has approached the surgical technique from a point of view that differs from other books on operative technique. The author is concerned with the prevention of postoperative complications which are based on mistakes made in the operating theatre. His approach has been effective. The illustrations are of excellent quality and are appropriate to the text. The figures on the right-hand page illustrate the operative technique admirably. The text on the left hand page describes the steps to be taken in performing the operation and, in addition, warn of the serious complications that may occur. There are a number of line drawings to depict potential complications and errors. A number of cogent admonitions are placed in italics. The operations depicted are for the most part the standard procedures which are performed by general surgeons. The operative technique employed by the author is sound and well presented.

Most of the criticisms are minor. The pyloroplasty illustrated is open to some question. The extent of the incision on gastric side is less than most surgeons have found satisfactory. The insertion of the illustrations for the treatment of esophageal stricture between gastric surgery and colon surgery is puzzling. It would seem more suitable to have this section adjacent to the treatment of diaphragmatic hernia. One may take exception to the author's statement that a pear-shaped portion of colon must be removed to open a colostomy. Inguinal hernia repair is illustrated in detail, but repair of umbilical hernias is omitted. Transabdominal adrenalectomy is presented without reference to the flank approach.

However, these remarks do not detract from the overall high quality of the volume and the sound advice given throughout the text. The book should be of interest to general surgeons and should be particularly valuable to surgeons during their residency training.

John M. Beal, M.D.

SURGERY OF THE AGED AND DEBILITATED PATIENT

Edited by John H. Powers, M.D. W. B. Saunders Co., 1968.

Growing numbers of our population are living beyond 65 years of age. These elderly patients account for a disproportionately high percentage of our total surgical cases. The surgical mortality rate in this population is much higher than the general population. These facts, statistically supported in the introduction, lay the foundation for this excellent 596 page volume which deals intimately with the problems encountered in the surgery of the aged patient.

Beginning with a discussion of the physiology of aging, the authors review the changes which occur in the vital systems of the body as the patient grows older. They conclude that the elderly patient has an overall reduction in his reserve capacity to respond to stressful situations, and that in general, this is due to a gradual reduction in the number of functioning elements within vital organs.

Further chapters are devoted to discussions of the recognition, preoperative evaluation, and postoperative management of factors which affect surgical mortality in the elderly patient. Metabolic changes, nu-

trition, anesthesia, coexisting diseases, response to infection, and psychology of the aged patient are discussed.

Later chapters discuss specific surgical diseases. Although each chapter is written by a different author, the emphasis is the same throughout. Whereas other surgical texts choose to concentrate on surgical diagnosis or surgical technique, this book emphasizes the surgical judgment involved in choosing the right operation and the right time for surgical intervention in the elderly patient. This basic theme is succinctly stated by J. Englebert Dunphy in his discussion of "Elective Surgery in Old Age," "At best we hope to cure the disease and restore this patient to complete health, but health in the aged is often a relative matter and there are times when the best we can do is do no harm."

As one reads this book, he is impressed by two basic principles of geriatric surgery which Editor John H. Powers summarizes in the final chapter, "The eradication of basic primary disease, even when asymptomatic, before often lethal complications ensue. The reduction to a minimum by prevention, early diagnosis, and prompt therapy of the frequently fatal postoperative complications which are truly manifold." As a final emphasis, he reviews the surgical experience at the Mary Imogene Bassett Hospital and produces irrefutable statistical support of the importance of these concepts.

The contributing authors of this book are world recognized authorities in the field of geriatrics. Their vast clinical experience provides the reader with a valuable insight into the special problems encountered in surgery of the aged patient.

Stuart M. Poticha, M.D.

Film Reviews

The International Film Bureau, Inc., 332 S. Michigan Ave., Chicago, 60604, has announced the publication of a new Catalog of Filmstrips. The catalog contains descriptions of 190 film strips in fine arts, English, drama and language arts, modern foreign language, health, welfare, guidance and safety.

A revolutionary concept and technique-treatment of shock by vasodilation-is depicted in a new film, "Lillehei on Stagnant Shock." Part of the Upjohn Company's award-winning Vanguard of Medicine Series, the 21 minute, 16 mm., color film is available free to professional groups from Upjohn's Professional Film Library.

This is a report of the gynecologic profile of the single late teenager. The purposes of this report are to demonstrate the multitude of apparent psychosomatic gynecologic symptoms in this age group who generally are in excellent health with normal reproductive organs, and to emphasize the benefits of gynecologic education and examination prior to their entry into womanhood. It is believed that with such information, the young lady will be better prepared to assume the role of a mature female which today is cast upon her at an increasingly early age.

Gynecologic Profile of The Late Teenager

BY ROBERT E. LANE, M.D./CHICAGO

Robert E. Lane, M.D., is assistant professor, Dept. of Obstetrics and Gynecology, Northwestern University Medical School, as well as senior attending physician, obstetrics and gynecology, Chicago Wesley Memorial Hospital. He received his M.D. degree from the University of Illinois College of Medicine. In addition, Dr. Lane is a Fellow of the American College of Surgeons and the American College of Obstetrics and Gynecology.



Materials And Method

A complete medical history is obtained and a physical examination is done on each student entering the School of Nursing, Chicago Wesley Memorial Hospital. The gynecological examination is performed by a member of the Department of Obstetrics and Gynecology. Prior to the gynecological examination, a lecture is given to the student group on the anatomy and physiology of the reproductive organs, the value of the cytologic smear, and the method of the bi-manual vaginal-abdominal or recto-abdominal examination.

One hundred seventy-five students entered the nursing school during the period of study included in this report. One hundred forty-two (81.1%) of these students were 17, 18, or 19 years of age. This report is concerned with these latter students under 20 years of age.

History Results

Physical discomfort with menses:

One hundred thirty (91.5%) of the subjects indicated that physical discomfort occurred with their menses. One hundred fourteen subjects stated that the discomfort occurred cyclically since menarche, but in 16 occasionally or rarely.

The order of frequency of menstrual complaints was cramps, irritability, mood change, fatigue, back-ache, breast tenderness with swelling of the breasts, pelvic pressure, nervousness, headache, and consti-

pation. The 130 subjects with symptoms listed 485 total symptoms. These complaints were present prior to, during, or after the onset of the menstrual flow. Twelve of the subjects stated there was a seasonal variation to the symptomatology. Approximately 50% of the subjects had consulted a physician for the menstrual discomfort, and medication was prescribed for the majority of these patients.

One-third of the subjects with menstrual complaints had on various prior occasions failed to participate in scheduled social, school, or athletic events because of the symptoms. The majority of the subjects stated they were more irritable or fatigued prior to menstruation, whereas only a few subjects stated they were more active physically and mentally at that time.

The majority of the subjects stated they were not frightened at the onset of their first menstrual period and that menstruation had been explained to them prior to the first menses. The explanations primarily came from the mothers of the subjects.

Menstrual Hygiene

The following tables illustrate the method of menstrual hygiene practiced by

Table I
Forms of Menstrual Protection Now Used

Age	Number of Subjects	External	Internal	Combination External and/or Internal
17	16	9	3	4
18	107	52	25	30
19	19	10	3	6
TOTAL	142	71	31	40

the subjects. Of the 96 subjects who have tried internal menstrual protection, 31 have continued this method exclusively and an additional 40 subjects use either internal tampons or external pads according to their amount of menstrual flow. This is significant in that the teenager in the majority of cases has knowledge of the location of the hymenal orifice and has not found the use of intra-vaginal menstrual protection too difficult or objectionable.

The reasons stated by the subjects for not using external pads were: bulk, discomfort, unable to conduct exercises or to swim, odor, chafing, or inconvenience. Subjects who had tried internal tampons, but who no longer use them, gave the following reasons for their discontinuance: difficult insertion, uncomfortable, difficult removal, and inadequate protection.

Table II
Forms of Menstrual Protection Tried

Age	Number of Subjects	External	Internal
17	16	15	10
18	107	104	73
19	19	18	13
TOTAL	142	137	96

Table III
Age at First Use Of External Pads

Age	Number of Subjects	Age tried (years)						
		9	10	11	12	13	14	15
17	15		2	4	5	4		
18	104	1	5	12	40	35	8	3
19	18		1	2	3	7	2	3
TOTAL	137	1	8	18	48	46	10	6

Table IV
Age at First Use Of Internal Tampons

Age	Number of Subjects	Age tried (years)								
		11	12	13	14	15	16	17	18	19
17	10				1		4	5		
18	73			1	5	13	23	23	8	
19	13	1				2	5	1	3	1
TOTAL	96	1		1	6	15	32	29	11	1

Urinary Incontinence

Twenty-one subjects (14.1%) stated there was periodic loss of urine upon coughing, sneezing, laughing, or excitement. None of the subjects related the urine loss to menstruation. The urinalysis on each of these subjects was normal, as well as the examination of the reproductive organs. One subject with frequent urinary incontinence had had, prior to entry into the nursing school, a complete urological examination which was normal.

This interesting but unexplainable finding in the history of the foregoing subjects lessens somewhat the significance of a similar history with normal urological and gynecological findings in subjects in older age groups.

Gynecological Examination Results

Gynecological examination was done on each of the 142 subjects. The following table lists the type of examination performed:

The ten subjects in whom a single finger vaginal-abdominal examination could not be performed had hymenal openings too small to permit such examination. In the judgment of the gynecologist performing the examination, a partial hysterectomy would be necessary in those ten subjects prior to adequate examination or to first coitus. These subjects were instructed regarding their findings and were reassured as to the normalcy of their reproductive organs by rectal-abdominal examination.

Table V
Type of Examination

Age	Number of Subjects	Vaginal- Abdominal	Rectal- Abdominal
17	16	15	1
18	107	98	9
19	19	19	
TOTAL	142	132	10

Speculum vaginal and cervical examinations were readily accomplished in 132 subjects using Lawton vaginal specula. Cytologic smears of the cervix were taken in each of these subjects. An eversion of the cervix was noted in 19 subjects. The cervix descended to the introitus on straining in one subject. Two of the smears were atypical, but proved to be related to a non-specific vaginitis in each case inasmuch as the smears were normal after clearing of the vaginitis.

The external genitalia were normal in all the subjects. There was some degree of retrodisplacement of the uterus in 26 subjects, and ovarian cysts were palpable in three subjects. On re-examination, the cysts had disappeared demonstrating them to have been physiological enlargements of the ovaries rather than neoplasms.

Mensuration Of Introitus

As a part of this study and in particular to demonstrate in a valid manner that late teenagers may adequately be examined vaginally in the majority of cases, the hymenal orifices were measured in 132 subjects. Ten subjects had too small a hymenal orifice to permit mensuration. Modified Lawton specula specially calibrated to elicit diameters and corresponding cross-sectional areas of the hymenal orifices were used.

Table VI
Hymenal Mensuration
Age 17

Number of Subjects	Hymenal Orifice Area in Square Centimeters	Subjects Using Internal Tampons
4	2.50	0
3	3.00	2
2	3.50	1
3	4.00	2
3	4.25	2
TOTAL 15		7

Table VII
Hymenal Mensuration
Age 18

Number of Subjects	Hymenal Orifice Area in Square Centimeters	Subjects Using Internal Tampons
5	2.00	2
10	2.25	0
8	2.50	3
25	3.00	14
10	3.25	7
23	3.50	17
6	3.75	4
11	4.00	8
TOTAL 98		55

Table VIII
Hymenal Mensuration
Age 19

Number of Subjects	Hymenal Orifice Area in Square Centimeters	Subjects Using Internal Tampons
1	1.25	0
3	2.25	1
2	3.00	0
4	3.25	2
5	3.50	2
2	4.00	2
2	4.50	2
TOTAL 19		9

Tables VI, VII and VIII list the results of the hymenal mensuration. All of the subjects with hymenal measurements were examined by single finger vaginal-abdominal examination. Further evidence, other than mensuration, that the hymenal orifice size may permit gynecologic examination is the correlation between the areas of the hymenal orifices obtained and the use of internal tampons for menstrual protection as noted in Table IX.

Under the circumstances of this study a specific inquiry regarding prior sexual

intercourse could not have been presumed to produce reliable information. Hence, no effort was made to obtain such data.

Summary And Comment

This gynecologic profile of late teenagers characterizes them as having many psychosomatic symptoms referable to the reproductive organs which generally are present in the absence of pathology in these organs. Adequate gynecologic examination may be accomplished in most members of this age group as demonstrated by valid hymenal mensuration in 132 of 142 such individuals.

It is believed by the author that all female teenagers entering adulthood by virtue of their assumption of independency upon leaving home to attend schools for higher education or for other reasons should be examined gynecologically by competent physicians prior to their undertakings. At that examination there is opportunity for the physician to dispel from the patient's mind any previously acquired misinformation about the reproductive organs, and to offer assurance to the majority of such patients that they are normal gynecologically. Sex education of the female, as formally or informally being carried out today, is totally inadequate if the female has no knowledge of the status of her pelvic organs. ◀

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Table IX
Relation of Hymenal Mensuration
To Use of Internal Menstrual Protection

Hymenal Orifice Area in Square Centimeters	Number of Subjects	Now use Tampons Number	Percent
1.25	1	0	0
2.00	5	2	40%
2.25	13	1	7.6%
2.50	12	3	25%
3.00	30	16	53%
3.25	14	9	64%
3.50	30	20	66%
3.75	6	4	66%
4.00	16	12	75%
4.25	3	2	66%
4.50	2	2	100%
	132	71	53.7%

Right Pneumonectomy Complicated by Cardiac Arrest in Pregnancy

By J. H. ISAACS, M.D., W. M. LEES, M.D., R. T. FOX, M.D.,
AND J. TARNOFF, M.D./CHICAGO

Case Report

The authors of this article are affiliated with the Chicago Municipal Tuberculosis Sanitarium. John H. Isaacs, M.D. (left), is

Chairman of the OB-GYN Department, St. Francis Hospital, Evanston, and Clinical Professor at Loyola University Stritch School of Medicine. William M. Lees, M.D. (not pictured) is a Trustee of the Illinois State Medical Society. He is a thoracic surgeon, a graduate of Rush Medical School. Dr. Lees is Chief of Surgery at the Sanitarium as well as Clinical Professor of Surgery and Chief of Cardio-Pulmonary Surgery, Loyola University Stritch School of Medicine. Robert T. Fox, M.D. (not pictured) is a graduate of Northwestern University Medical School where he is currently Assistant Professor of Surgery. He is also Assistant Chief of Surgery at the Sanitarium. Joseph F. Tarnoff, M.D. (right) a graduate of the University of Illinois College of Medicine, is a specialist in Thoracic surgery and has served on the staff of the Veterans Administration Hospital, Hines.



A series of 29 major thoracic operations performed on pregnant women at the Chicago Municipal Tuberculosis Sanitarium during the years 1952 through 1966 has recently been reported.¹ Twenty-eight normal babies were delivered at term and there was one stillborn premature delivery. One of these 28 patients had a cardiac standstill during surgery with a successful outcome for the mother and infant. Sufficient time has now elapsed to assess any residual damage that might have resulted from the period of intrauterine anoxia. Because of the unusual nature of the cardiac arrest and the subsequent prolonged follow-up of the infant, a report of this case seems warranted.

Mrs. I.B., a 32 year para 5005, white female, was admitted to the Municipal Tuberculosis Sanitarium on November 18, 1955. The admission chest film revealed far advanced active pulmonary tuberculosis with numerous cavities, several of which contained fluid levels, principally in the right upper and lower lobes. Two of three sputum cultures collected on admission were positive for tubercle bacilli.

The patient was treated with streptomycin.

cin, para-aminosalicylic acid and isoniazid. Pneumoperitoneum was initiated in July, 1956, because of a persistent endobronchitis of the right main stem bronchus.

The pneumoperitoneum was discontinued on November 5, 1956, after pelvic examination confirmed the presence of an intrauterine pregnancy of approximately 16 weeks duration. The last normal menstrual period was June 22, 1956. Her expected date of confinement was March 29, 1957.

On November 30, 1956, the patient was evaluated for possible thoracic surgery. Her maximal breathing capacity was 74% of predicted. Because of the persistence of extensive cavitory disease in all lobes of the right lung, resection of the right lung was recommended. On December 17, 1956, at which time she was 28 weeks pregnant, the patient underwent right pneumonectomy. Excerpts from the operative report follow:

"We started to repleuralize the bronchial stump, but at this time, exactly 11:07 a.m., we noted a cardiac standstill. We started extrapericardial massage immediately and we noted very little active contraction of the cardiac muscle. At 11:10 a.m., or three minutes after the cardiac standstill, the pericardium was opened and we started intra-pericardial cardiac massage, after injecting 10cc.'s of calcium chloride. The return of cardiac function was immediate and at 11:11 a.m., or four minutes after the initial cardiac standstill, the heart was beating at its former rate."

The remainder of the procedure was accomplished without incident and the patient had an uneventful post-operative course. The only change noted in the patient's post-operative electrocardiogram was a diphasic T wave in lead V₄ which was ascribed to cardiac position.

Prior to surgery, the fetal heart tones were normal, but were not heard post-operatively, nor could the patient appreciate any fetal movements. Thus, fetal demise was suspected. Three weeks post-operative (January 9, 1957) the patient noted fetal movements, and fetal heart tones were again audible. The remainder of the prenatal course was uneventful.

On March 18, 1957, an assisted breech delivery of an apparently normal 2,580 gram male infant was accomplished. The child has subsequently developed normally and has maintained an academic status commensurate with his chronological age. His moral character likewise appears normal; this observation is based on the fact that he is an altar boy in his local parish.

Discussion

Most of the available literature on cardiac arrest in pregnancy has concerned itself with etiology, prophylaxis, treatment and the impact on the maternal mortality rate.²⁻⁵ In those cases that were successfully treated, no mention is made of the long term child development. This case does serve to emphasize that with adequate treatment a normal delivery and subsequent normal physical and mental child development can result. ◀

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Manual on Alcoholism

As proof of the popularity and timeliness of the *Manual on Alcoholism*, more than 10,000 copies have been distributed since its release late October, 1967. This 100-page publication, "intended to give physicians a brief outline of the major factors in the causes, diagnosis and treatment of alcoholism and the medical management of alcoholic patients," is available for fifty cents in the U.S., Possessions, Canada and

Mexico.

Medical students, hospital interns and residents in these areas may obtain it for only forty cents. The price in all other countries is sixty cents. Requests should be directed to the American Medical Association, 535 N. Dearborn, Chicago 60610. To facilitate handling, orders should include payment and contain the code number, MH-3.

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago, 60601.

McDONOUGH COUNTY: Bushnell; population: 4,000. Trade area: 7,000. Four physicians until 1960. Avon Hospital, 10 miles; county nursing home also located here. Sixty miles from Peoria; 2 prescription drug stores. Financial assistance available. Agricultural and industrial community. Churches: Catholic and Protestant. Grade and high schools. Fifteen miles to Macomb golf course, pool, bowling alley etc. For further information contact: Jack Gordon, 528 E. Main St. Phone: 772-3218 or 772-2036 (home).

McDONOUGH COUNTY: Macomb; population: 19,000. Trade area: 40,000. Sixteen physicians in county; including 10 general practitioners. McDonough District Hospital, 190 beds, located here. Office space available; including space in six-year-old Erdman Bldg. located next to hospital, completely furnished and equipped. New, unfurnished office also available next to hospital. Agricultural area. Western Illinois University located nearby. Four small factories. Churches: 22 Protestant and Catholic. Grade and high schools. Country club with golf course and pool; municipal pool also. Six golf courses. Excellent cultural facilities. For further information contact: Donald Sexter, M.D., Doctor Lane. Phone: 309-833-4176.

McHENRY COUNTY: Huntley; population: 1,100+. Community owned medical center built in 1959; occupied by dentist full-time; six rooms reserved for phy-

sician. Nearest doctors at Woodstock, Crystal Lake and Elgin, 10 miles. Six hundred hospital beds in Elgin. Agricultural area with some industry. Churches: Congregational, Catholic and Lutheran. Grade and high schools. Three golf courses in area. Located 50 miles northwest of Chicago off Interstate 90 tollroad. Expanding area close to lake region. New modern drug store. For further information contact: Wayne Miller, State Bank of Huntley, Huntley; Phone: 669-5151.

McHENRY COUNTY: Richmond; population: 1,000. Sixty-five bed hospital, now expanding, 18 miles away. Houses for rent and for sale. Lake region. Churches: Lutheran, Catholic, Southern Baptist and Community (Congregational and Methodist). Three schools. Sixty miles from Chicago. Organizations include the American Legion and Rotary. Hunters Golf Club, good swimming, hunting and boating in lake region. For further information contact: Mr. Fred Schroeder, R.Ph., or J. F. Harris, M.D., Richmond.

McLEAN COUNTY: McLean; population: 700. Only physician recently moved to specialize in radiology. Nearest physician at Bloomington, 15 miles, and Atlanta, 4 miles. Several hospitals at Bloomington. Located 45 minutes from Springfield. Local drug store. Good office space available. Equipment of former physician available, if desired. Financial assistance also available if desired. Agricultural community. Churches: Methodist, Christian and Church of God. Grade and high schools. For further information contact: Dean Walters, Box 115, McLean. Phone: 874-3411 or 874-3511.

McLEAN COUNTY: Bloomington-Normal; population: 57,000. Trade area: 100,000. Hospitals: Brokaw, Mennonite and St. Joseph's. Located 40 miles from Peoria. Ten drug stores. Multiple office facilities available—downtown to outlying districts. Financial assistance can be arranged. Agricultural and industrial area. Grade schools, 26; high schools, 4; country clubs, 2; golf courses, 5; swimming pools, 2. For further information contact: R. E. Baxter, M.D., 401 W. Virginia Ave., Normal, 61761. Phone: 967-6094.

In 1966, there were 399 practicing pediatricians in Chicago,¹ 514 practicing pediatricians in the state of Illinois,² and only 10,089 practicing pediatricians in the whole United States.³

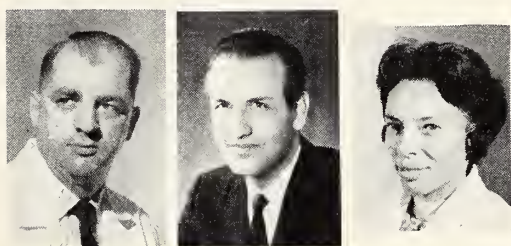
In addition, whereas in 1930, 85% of the United States' physicians were in general practice, today only about 35% are, and it is estimated that only 18% of this year's medical graduates will go into general practice.

The vast majority of child health services are provided by either general practitioners or pediatricians. In 1940, there were a total of 337 practicing pediatricians and general practitioners per 100,000 children under the age of 15. By 1963, this ratio fell to 133 per 100,000.⁴

With the current shortage of child care physicians estimated at approximately 70,000,⁵ it is now being generally appreciated in this country that there is a crisis in child care and that this is a matter of critical concern to all.

CRISIS IN CHILD CARE

BY JOSEPH R. CHRISTIAN, M.D.,
ALBERT L. PISANI, M.D.,
AND IRIS SHANNON, R.N./CHICAGO



Albert L. Pisani, M.D., (left) is Chief of Pediatrics, the Mile Square Health Center, Presbyterian-St. Luke's Hospital, Chicago. He received his M.D. from Loyola University, Stritch School of Medicine, and served his residency at Mercy Hospital. He is certified by the American Board of Pediatrics and is a Fellow of the American Academy of Pediatrics. Dr. Pisani is also an Assistant Professor of Pediatrics, the University of Illinois College of Medicine. Joseph R. Christian, M.D., (center) is Chairman, the Division of Pediatrics, Presbyterian-St. Luke's Hospital. He served his residency in pediatrics at Cook County Hospital and has taken postgraduate training at Harvard's Children's Hospital. Dr. Christian is Professor of Pediatrics at the University of Illinois College of Medicine. Iris Shannon, R.N., is a Director of Community Nursing, the Mile Square project, and has specialized in Public Health Nursing. She is a graduate of Fisk University and has an M.A. from the University of Chicago.

The setting of goals should be a realistic process rather than merely an exercise in rhetoric. It should be quite obvious that if goals are to be reached, resources necessary must be either available or potential.

There appear to be three methods by which child medical care may be increased: 1) increase the number of physicians rendering child care; 2) increase the productivity and efficiency of physicians caring for children; 3) increase the utilization and efficiency of available paramedical personnel. Past experience indicates that there is a time span of at least ten years from the planning stage of a new medical school to the graduation of its first class. Three more years must be added to complete the required training program in pediatrics.

If it were possible to increase significantly and rapidly the number of pediatricians in the United States, this would not insure practicing physicians with offices in areas of greatest need—Urban Centers of poverty and rural Appalachia. Available data indicate that more than half of all American pediatricians are located in just seven states: New York, California, Pennsylvania, Illinois, Texas, Ohio, and Massachusetts. Obviously there is not only a shortage of supply but a maldistribution.

It is the opinion of many in the field, including pediatrician William Stewart, Surgeon General of the United States, that the physician-manpower needs cannot be met.⁶

Make the Best Use of Personnel

Increasing the productivity and efficiency of physicians caring for children can be accomplished through careful analysis and experimentation to identify those functions which **MUST** be performed by a pediatrician and those which can be performed satisfactorily by a professional nurse.

The pediatrician, with over a decade of education beyond the high school level, should use his time in the performance of those tasks which he alone is prepared to do. He is otherwise not only practicing in an inefficient manner, but lack of stimulation may cause him to lose his highest professional skills and the stimulus to continue his own education.

Various studies have revealed that well-child examinations, occupying 30% to 65% of a pediatrician's time, are the greatest reason for office visits in pediatrics. This has been true for over a quarter of a century. Studies by C. A. Aldrich⁷ in 1934, and Bergman⁸ in 1966, indicated strikingly similar experiences.

The physician should be able to delegate most of this care to personnel not requiring his long education and training.

As Fein⁹ has pointed out, a mere 5% increase in the productivity of existing private general practitioners and pediatricians would add the equivalent of 3,900 physicians, more than the annual number now entering general practice and pediatrics.

How Time Is Spent

At least 50% of a pediatrician's time is spent on well-baby care or "Preventive

Pediatrics," two-thirds of which a less well-trained person could provide, thereby increasing the productivity of existing pediatricians by 33%. This would immediately add the equivalent of 3,000 practicing pediatricians to the nation's manpower pool.

Paramedical Personnel

More efficient utilization of paramedical personnel must be seriously considered. One of the recommendations of the National Advisory Commission of Health Manpower was that nursing should be made a more attractive profession by such measures as appropriate utilization of nursing skills and increased levels of professional responsibility.

The nursing profession in this country has never developed its full potential because of the traditional attitude held by both nurses and physicians that the nurse is primarily the physician's assistant. These "at the elbow" helpers are luxuries that this nation can no longer afford. In the trades, helpers, after a period of apprenticeship, eventually become journeymen.

The field of pediatrics has become very complex as a result of the rapid expansion in knowledge in many areas affecting child care: metabolic disturbances, genetics, newer diagnostic and therapeutic methods. At the present time, the pediatrician's interest in the patient begins at the time of conception and continues on through adolescence. In order to keep abreast, pediatricians should have more time for continual post graduate education.

Child Care

Routine child care has changed greatly in the last quarter century. With the disappearance of many infectious and nutritional disorders, current emphasis is on preventive pediatrics. Many pediatricians feel that nurses may not only do just as good a job, but may even do a better job of child care than the pediatrician.

The pediatrician should be responsible for the qualification, performance and supervision of paramedical personnel on the child care team. Instruction in the methods and standards should be his responsibility. He must be available for consultation at all times in order to evaluate all suspicious or abnormal findings presented to him by the Nurse-Pediatrician. He should perform

the *Initial* medical evaluation on all patients before referral to the Nurse-Pediatrician for subsequent care.

Skills required by the Nurse-Pediatrician include knowledge of development, human relations, social studies, behavior counseling, nutrition; in addition there must be basic preventive pediatric training. Feminine intuition gives nurses two additional natural attributes: a warm and understanding nature, and intuitive insight and sensitivity to the needs of children.

Functions the Nurse-Pediatrician can perform readily include:

1. Routine History Taking
2. Routine Physical Examination in Infants
3. Anticipatory Guidance:
 - a. Accident Prevention
 - b. Growth and Development
4. Infant Nutrition
5. Immunization Procedures
6. Treat Minor Disorders and Diseases:
 - Common Colds
 - Contagious Diseases
 - Minor Gastrointestinal Upsets
 - Constipation
 - Heat Rash
 - Poison Ivy
 - Mosquito Bites
 - Contact Dermatoses
 - Diarrhea
 - Formula Adjustments
 - Pinworms
 - Impetigo
 - Athletes Foot
 - Diaper Rash
 - Intertrigo
 - Atopic Eczema
 - Sunburn
 - Minor Burns
 - Minor Lacerations
 - Contusions and Abrasions
 - Gastric Lavage
7. Pediatric Screening—The Nurse-Pediatrician can evaluate the presenting problems and determine whether the problem is acute and in need of care at the present time or whether the child can be given an appointment at a more appropriate time.
The Nurse-Pediatrician is equipped to handle many of the problems because of her own skills and experiences. She can discuss the presenting problems and give guidance and advice.
8. Exit Interview with Mothers—The

Nurse-Pediatrician can interpret physicians' orders, handle referrals and use this opportunity for teaching.

Application of Concepts

The Mile Square Health Center has utilized Nurse-Pediatricians during the past year. Nurses who have functioned in this role have found their task very satisfying. The opportunity to provide primary rather than merely ancillary patient care allows these nurses to more fully utilize their training and experience. Another possible fringe benefit is that the increased prestige of the Nurse-Pediatrician might also attract more men into nursing.

One criticism sometimes heard is that with the current shortage of registered nurses, the conversion of these nurses to Nurse-Pediatricians would only serve to aggravate the shortage of nurses. The obvious answer to this is that many of the tasks currently performed by registered nurses could readily be performed by practical nurses and nurses' aides with a little additional training. These latter paramedical personnel are more readily available than registered nurses.

Obstacles to Newer Concepts

Before this system can be widely used, certain obstacles must be faced. The question is: since well-baby care is more concerned with the care of the mother than the baby, would a mother receive the same reassurance from a nonphysician? It appears that this question cannot be answered without public education.

It will also be necessary to update restrictions of the Medical Practice Act. Maximum utilization of personnel is hindered by outmoded limitations which have been incorporated into licensure and certification codes of professional personnel. Although originally designed to insure a high quality of patient services, these currently serve as effective roadblocks to effective and efficient utilization of available health manpower resources.

It is socially uneconomical to utilize any person at a lower level than that to which her training or experience qualify her, nor should persons be given tasks at a higher level than that for which they are capable. It is extremely important that this nation use its existing supply of health manpower most effectively.

(Continued on page 640)



AMERICAN ETHNIC POLITICS Lawrence H. Fuchs. Editor; Harper & Row, New York, 1968; \$2.45.

In recent years historians, political scientists and sociologists have vied with each other in attempting to probe the intricacies of ethnicity and politics. Editor Fuchs attempts three things in *American Ethnic Politics*: (1) to explain the theory of the interrelationships between ethnicity and politics in the U.S.; (2) to exemplify the confrontation of important ethnic groups with American policy; (3) to append a summary bibliographic essay and bibliography which enables the reader to canvass the work that has been done and to highlight some of the issues which need further exploration.

The United States never has had an ethnic political party but ethnic groups have constituted subparties or factions within the major parties. At only one point in American history has there been a religious party. Archbishop John Hughes of New York sponsored a slate of Catholic candidates in 1840 to protest against what Catholics saw as the Protestantization of the public schools. Hughes showed what Catholic power could do when he took enough votes away from the Democratic candidates to frighten the Democratic leadership in upper New York State into partial support of Catholic-sponsored legislation.

Editor Fuchs maintains that politics embraces much more than a distribution of power of the structure of decision making. "One fascinating thing about politics," he says, "is the ways in which people pursue or avoid power and the kinds of political issues and personalities which involve men in the competition for power. These are the aspects of politics which require an understanding of the subtleties and nuances of ethnic memory and cultural inheritance."

Politics in America has been an important factor in promoting the persistence of ethnic identity. The major characteristics of American political life often place a premium on group cohesiveness. In democratic politics as opposed to aristocratic politics (born out of a feudal tradition) justice has to be fought for. Justice is not the result of each getting his share according to a prescribed network of reciprocal obligations and mutual benefits. Rather, it is the product of an open competition among various kinds of groups including ethnic groups. In such a system, cohesion—a strong group identity—is an important ingredient of power.

It is clear that every ethnic group has its own distinctive style of cognition, perception, feeling and behavior. How those styles manifest themselves in politics is not as obvious. Although the author concedes that ethnicity is not necessarily a cause for behavior, he believes that under certain conditions at certain times for certain groups, there is a relationship between the psycho-cultural inheritance of ethnic groups and their political behavior.

American Ethnic Politics is well seasoned with examples of ethnic voting patterns in various com-

munities, results of polls and surveys conducted over the years, and brief glimpses of the cultural history of some groups.

DECISIONS FOR A DECADE Edward M. Kennedy; Signet, New York, 1968; 95¢.

Senator Kennedy has written an interesting and well-documented study of domestic and foreign issues facing the U.S. Mr. Kennedy does not list a series of problems and difficulties, but rather, discusses solutions to the present conditions.

In examination of the military selective service system, the author contends that the draft has become the major civil liberties issue of the Vietnam war. He states: "It is undeniable that some who oppose the draft do so purely on grounds of personal convenience. They would object to service no matter what the cause and no matter how fair the system. But we should also recognize that much of the opposition and much of the evasion is triggered by the way the draft works. The plain fact is, our selective service system is an obsolete, irrational and wholly unfair institution. Its recruitment system is locked into arbitrary, incomprehensible patterns of operation."

A volunteer army may be a solution. With more than 60% of our present military manpower met through enlistments, the proposal, Kennedy feels, is worth consideration. Military service, next to criminal punishment, is the strongest degree of control the government has over citizens. A volunteer army in lieu of compulsory service would cost an estimated \$4,000,000,000 to \$20,000,000,000 a year. The Senator feels this is too high a price to pay in view of other domestic problems—slums, educational and job opportunities, air and water pollution.

Instead, Mr. Kennedy favors reform of the present draft laws: (1) the drafting of men at an early age (19); (2) the drastic curtailment of deferments, with the choice for service made on a random selection basis. College deferments would be abolished in wartime but four-year college postponements would be permitted in peacetime.

Another domestic issue—that of crime control—is discussed extensively by Senator Kennedy. He examines the Courts and the Constitution, the police and the penal system, crime technology and firearms. It is vital, he asserts, that we prevent the lawless and irresponsible from the use of guns.

Giving equal time to other issues, the racial crises are surveyed along with the problems inherent in a republic.

The second half of the 200-page book includes NATO, the Non-Proliferation Treaty, Germany and Berlin, Overcommitment in Asia, Communist China, Latin America and Japan.

In toto, *Decisions for a Decade* offers interesting analyses and suggests solutions to many problems. Though many will not agree with Senator Kennedy's opinions, the book provides a stimulating and well-documented discussion of both old and new problems. ◀

Challenges Facing Regulators and Regulatees

BY BERNARD L. OSER, PH.D./MASPETH, NEW YORK

Hundreds of papers and reports have been written and thousands of speeches have been delivered on the dual problem of the population explosion and the lagging food supply. It would be folly to deny the reality of this sword of Damocles that hangs over the collective heads of mankind today. We are witnessing a race between the obstetrician and the farmer. One need only look back over the record of the past half century to realize that Old Man Malthus was right after all.

Advances in medical science during this period have resulted in marked lowering of the death rate particularly from the infectious diseases of infancy and childhood. Hopefully the future portends still further lowering of the death rate by the alleviation of hunger and malnutrition. This should result in greater productivity, not only through survival of greater numbers into adulthood, but through improved physical and mental performance.

Bernard L. Oser, Ph.D., is from the Food and Drug Research Laboratories, Inc., Maspeth, N.Y.

This is the first in a series of five papers presented at the Symposium on Nutrition and Food Technology, Chicago, in February, 1969. The symposium was co-sponsored by the ISMS Nutrition Committee, the Chicago Nutrition Association, and the Chicago Section of the Institute of Food Technologists. Paul Dailey, M.D., Chairman of the ISMS Committee also served as co-chairman of the Symposium. These papers relate to many facets of food technology, adequate nutrition, convenience foods, and like considerations.



Paul A. Dailey, M.D.

Another portent for the future is the fact that colonialism is going out of fashion. People throughout the world are seeking liberation from their alleged exploiters and new nations are proliferating at an unprecedented rate. That they are not agriculturally, industrially, or politically prepared for independent existence has not hindered their emergence as free nations. Whether we call these countries underdeveloped or, more euphemistically, underprivileged, they will continue to be a threat to world peace as long as their basic human needs are not met. It is not only a moral but a political necessity, in our own national interest, to contribute to the security and prosperity of underprivileged populations throughout the world. Improved nutrition, higher standards of sanitation and medical care, better and more extensive education and training, these are the keys to the future peace of the world.

How can food scientists and technologists help meet this challenge? In the past generation we have learned enough about what constitutes an adequate diet to realize the causes of hunger and malnutrition, and the differences between them. Simply stated hunger is the lack of sufficient food to meet normal energy requirements. It is to be distinguished from appetite or the desire for food which surely is not lacking in starving populations. When hunger is alleviated by the consumption of protein-poor plant foods, the worst and most prevalent form of malnutrition rears its ugly head. In the United States and other advanced countries of the world, the various forms of malnutrition recognized as vitamin deficiency diseases, *viz.* rickets, scurvy, pellagra, etc., have been said to be virtually

eradicated, although recent surveys have indicated that this may not be entirely true. Cereal grains and root vegetables constitute the major source of calories in many parts of the world and these are notoriously low in protein, both qualitatively and quantitatively. Increased consumption of animal protein (meat, poultry, fish, milk, eggs) in the diet would be the ideal solution to the challenge of protein-calorie malnutrition were it not for the inefficiency of conversion of fodder to animal foods, and the problems of storage and distribution of these more perishable foods. To meet this challenge, food scientists must look to more economical and more stable sources of high quality proteins. These are derived mainly from oil seeds, such as soy and peanut, from new genetic varieties of corn and other grains, from whole fish and possibly from other marine sources. The future will see advances in amino acid fortification, in the production of leaf protein concentrates, and of single cell proteins from microorganisms. Each of these presents a challenge to plant physiologists, food scientists, and technologists, to the food processing and distributing industries, and to the governments of the highly industrialized countries.

Governmental Regulation

In the United States, the development of foods to meet special dietary needs is influenced to a major degree by the statutory controls. The regulations under the section of our Food, Drug and Cosmetic Act governing the labeling of foods for special dietary purposes were established over 20 years ago. Hearings were begun in June of last year on amendments proposed by the Food and Drug Administration which would severely restrict the promotion and sale of these foods. They have already filled 13,000 pages of detailed testimony, although thus far only a few government witnesses have been examined. The hearings have been marked by bitter cross-examination, and a battle of lawyers which may continue for at least another year, since several hundred witnesses for industry have yet to be heard. It is not my intention at this time to criticize this administrative proceeding, but rather to point out some of the consequences with respect to progress in the area of good nutrition.

Administration of our food laws and

regulations has a controlling influence on the types of products introduced into the market, not only in the United States, but in underdeveloped countries as well. No matter how great the need, these countries do not consider acceptable any foods exported from the U.S. which fail to meet our own standards of purity and safety. Thus, when the FDA establishes tolerances for pesticide residues, or conditions of use of food additives, or limitations on the enrichment or fortification of foods, these not only become factors which determine the quality of foods intended for the American public, but they have substantial impact on our international trade. The question has been raised, however, as to whether the Food, Drug, and Cosmetic Act which purports to "prohibit the movement in interstate commerce of adulterated and misbranded food, drugs, devices, and cosmetics, and for other purposes," actually confers authority to determine what the American public shall be permitted to eat. The Food and Drug Administration has proposed to limit the classes of foods that may legally be fortified with vitamins or minerals.

During the past year, the Council on Foods of the American Medical Association joined with the Food and Nutrition Board of the National Academy of Sciences-National Research Council in issuing a revised policy statement on the fortification of foods. It recognizes the need to broaden rather than restrict the classes of foods which can appropriately be fortified and is in contrast not only with an earlier pronouncement of these bodies but with the proposal now under consideration in the FDA hearings. The joint statement illustrates the desire of nutritionists for a liberalization of the former policy and the recognition that new or so-called imitation foods can make positive contributions to the human diet even in our own country.

The attitude of FDA was well revealed in the initial version of what became known as the crepe label which the proposed regulations would hang on vitamin and mineral supplements, *viz.* that these nutrients are supplied in abundant amounts by the foods we eat. That the presence of nutrients in foods is a far cry from their consumption was pointed out by many critics of this proposed label requirement. The later version of the crepe

label reads: "Vitamins and minerals are supplied in abundant amounts by commonly available foods."

Failure to meet dietary requirements from the "foods we eat" or from "commonly available foods" may be due to cultural or traditional preferences, to improper culinary practices, to faddism, to lack of nutritional education, to cost, or to other factors. When a prominent clinical nutritionist asserts that the crepe label might impede efforts to interest and educate physicians in the nutritional components of medical care, it is time to reconsider not only whether such labeling is indeed accurate, but whether it actually serves the interest of consumers.

Present food laws and their administrative application have imposed further barriers to the introduction of wholesome and nutritious foods. For example, FDA has opposed the enrichment of wheat flour or bread with lysine, on the ground that our population has sufficient access to other sources of complete proteins. We still have an archaic and unscientific statute on the books, administered by FDA, which proscribes the interstate shipment of a highly nutritious and economical food, filled milk. While FDA has finally given its blessing on whole fish protein concentrate, it has accompanied it with a kiss of death by requiring that the product be sold only in one-pound packages.

These examples should suffice to suggest that an appraisal should be made of the propriety of applying laws governing the standardization and labeling of foods toward setting limits on the sources and variety of safe and wholesome constituents of the diet.

Challenges to Increased Production

Let us consider some of the major challenges that face the food producing and processing industries. During the present century, miraculous achievements have been won in all areas of agriculture. So far, at least, Malthus' ominous foreboding of depletion of the soil has been successfully challenged by agronomists and engineers. Modern methods of irrigation, fertilization, plant breeding, and pest control have resulted in vastly increased yields and improved varieties of most of our important crops. Thanks to the use of ingenious agricultural machinery, this has been achieved

with a diminishing demand on labor. Farm population in the U.S. has been declining at the rate of 5% per year and now constitutes only 6% of the total population.

The accomplishments of the food processing and distributing industries have been not quite so dramatic although they are more apparent to the ultimate consumer. Foods in various stages of preparation are available in metal, glass, paper, and plastic containers of infinite variety. Packaging has contributed to the sanitary and keeping qualities of food and has facilitated distribution in self-service outlets, where the cost of containers is in part offset by the reduction in sales labor. However, current emphasis on convenience foods and packaging will not meet the challenge of the future food supply. The immediate problems of nutrition facing the world are largely localized shortages in essential nutrients, principally good quality proteins and sufficient calories. On top of this, the coming generation will have the burden of satisfying the needs of double the present world population.

We should be expanding our educational programs to provide the agricultural and technological resources and facilities required to sustain the burgeoning race of mankind. Nutritionists, economists, sociologists and physicians will play an increasingly important role in seeing that the right food gets to the right places.

In fulfilling the needs of people around the world, it is imperative to heed the advice of anthropologists that changes be in keeping with established food habits and "acceptable within the framework of their value system." Even in our own country we have learned that people will not eat novel foods just because they are "good for them." Bad food practices are not changed overnight into good practices. The causes of bad habits must be learned, whether they be geographic, economic, cultural, religious, or simply lack of education. We all know, for example, of the antipathy of Indians of South Asia toward slaughtering the sacred cow, but few realize the objection to cheese on the ground that rennet derived from the stomach of the ruminant is used in its production. We know of the stigma attached to baby foods when sold as specialty items for the senior citizen. We have learned of the problem

of promoting food mixtures designed specifically for malnourished, poor populations. In the near future, the main weapon against protein-calorie malnutrition will come from the adaptation of indigenous sources of food into familiar, acceptable forms.

Research and Development

Fortification of foods which fit into existing dietary patterns will depend on the availability at economically feasible cost not only of vitamins and minerals, but of amino acids and of protein concentrates from legume, marine and microbial sources. Blandness as well as nutritive value will be required of these concentrates to permit their introduction into acceptable food items. Food scientists in many countries are devoting their energies to the development of new types of protein concentrates and to the media through which they will be introduced into the dietary pattern. Corn, wheat, rice, and similar low-protein meals and grains, will probably be the major vehicles, but soups and beverages are receiving much attention as carriers of high quality proteins. Plant physiologists are selecting and propagating genetic strains of corn and wheat high in lysine which

should have an impact comparable to the development of rust-resistant wheat. Essential amino acids are being produced by microbiological fermentation at a cost which promises to make their use in food fortification more practicable than it is today.

Much of the research and development work needed in this area has little immediate prospect of financial return. With few exceptions, food companies lack the personnel and resources to undertake long-range programs leading to radical innovations in food supply. Certain of the large foundations have been outstanding in support of these undertakings, but principal support will have to come from governmental and international agencies. To this end it behooves our own government to offer greater encouragement and hope of reward to those industrial organizations with the competence and courage to venture into uncharted areas.

There are now one billion more mouths to feed on this planet than there were 15 years ago. Let us hope that some of the four billion dollars per year being spent in our explorations of outer space will be diverted to feeding the inner man before his numbers overwhelm us earthlings. ◀

Film Reviews

A new 13-minute color and sound film has been produced by the Volunteer Physicians for Viet Nam Program. Entitled "Bac Si My" (Vietnamese for "American Physician"), the film depicts the activities of a physician serving a 60-day tour under the AMA administered Volunteer Physicians for Viet Nam Program.

Designed for use by former volunteers, medical societies, service clubs and interested lay groups, this film is not a planned documentary but based on available footage from an Army medical officer who served in a provincial hospital for one year. Available through AMA, 535 N. Dearborn, Chicago, 60610.

* * * *

"A Storm-A Strife;" a 16 mm. film produced by the AMA's Dept. of Medicine and Religion. The 28-minute, sound-color production dramatizes a family's problems with children, health and marriage, and

draws attention to the need for a physician and clergyman to work together to serve the "whole" person and the "whole" family, and ways to do it. Intended primarily for use in medical society programming, the film is available through the AMA, 535 N. Dearborn, Chicago, 60601.

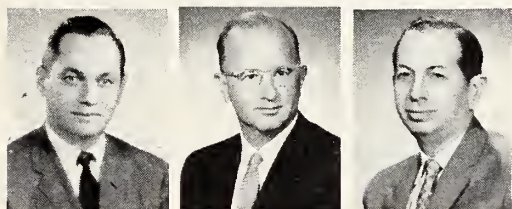
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"The Transplanters" is an absorbing 41-minute color motion picture that focuses on the moral, as well as the medical aspects of transplant surgery. It portrays with unusual candor the personal, sometimes divergent views of 17 of the world's most distinguished surgeons and specialists, including Barnard, Cooley, DeBakey, Shumway, Kantrowitz, Merrill, Harken.

A moving and perceptive documentary, the film is available on loan at no charge by contacting L. G. Foster, Dir. of Public Relations, Kilmer House 232, Johnson & Johnson, 501 George St., New Brunswick, N.J. 08903.

Survey of Visiting Privileges for Pediatric Patients in Hospitals

BY HARVEY KRAVITZ, M.D., ROBERT S. MENDELSON, M.D.
AND IRA M. ROSENTHAL, M.D./CHICAGO



Harvey Kravitz, M.D., (left) is a pediatrician and Assistant Professor of Pediatrics, Northwestern University Medical School. He is a graduate of the University of Illinois College of Medicine and is the *IMJ* Medical Progress Editor. He also serves at Children's Memorial Hospital. Dr. Robert S. Mendelsohn, M.D., (center) is a graduate of the University of Chicago. He is a member of the Hospital Care Committee and the Executive Committee of the Illinois Chapter of the American Academy of Pediatrics and Chairman of the ISMS Committee on Religion and Medicine. Ira M. Rosenthal, M.D., (right) is Professor of Pediatrics, the University of Illinois College of Medicine and has studied in Pediatric Endocrinology. He is Chairman of the Hospital Care Committee of the Illinois Chapter, American Academy of Pediatrics.

A statewide survey of visiting privileges for parents with children in hospitals in Illinois was conducted by the Hospital Care Committee of the Illinois Chapter of the American Academy of Pediatrics in 1967.

The primary purpose of the survey was to determine the present status of visiting privileges in the pediatric departments of hospitals in the State of Illinois. The committee was interested in determining whether additional hospitals have liberalized visiting hours since a previous survey conducted in 1960.¹ The committee wished to learn if there were now more facilities for mothers to stay over night with their hospitalized children.

A questionnaire was mailed to 146 hospitals in the State of Illinois with reported pediatric facilities. Replies were received from 106 hospitals including all major services. The number of pediatric beds in the hospitals reporting ranged from 5 to 500 with a mean of 39 beds per department. A significant increase since 1961 in the number of hospitals who have adopted unlimited visiting hours for children was found. (Table I)

Table 1 Summary of Visiting Privileges in Pediatric Departments of 106 Hospitals in Illinois		
UNLIMITED VISITING	LIMITED VISITING	DATE REPORTED
23 (21.7%)	82	1967
4 (3.7%)	102	1961

Of the 82 hospitals with limited visiting privileges for children, visiting hours ranged from 2 to 10.5 hours daily with a mean of 5.9 hours. In the 1961 survey the mean was 4 hours for private patients and 3 hours for ward patients for 137 hospitals.

Of 106 hospitals surveyed in 1967, 54 hospitals had increased visiting hours for pediatric patients since 1961. In 47 hospitals there was no change in visiting hours during this period. Five hospitals reported a decrease in visiting hours since 1961.

Table 2 summarizes visiting hours in 83 hospitals with limited visiting privileges. Unlimited visiting was allowed in most of these hospitals if a child was critically ill or emotionally upset. A physician's written request to the administrator for unlimited visiting was granted in most hospitals.

A survey of rooming-in facilities for parents revealed that many of the hospitals (53 of 106) have some type of overnight facilities. Ten hospitals have installed rooming-in facilities since 1961 and new facilities of this type are planned by 20 hospitals (Table 3).

Only 16 hospitals out of 106 hospitals responding to the survey permitted some type of visiting of hospitalized parents by

their children (Table 4). The great majority of hospitals not permitting visiting of this type are in Chicago. (A Board of Health ruling in Chicago has limited visiting of children in hospitals to those at 16 years or above.)

The Illinois Chapter of the American Academy of Pediatrics has long favored liberalization of visiting for parents of hospitalized children. This is in accord with the recommendation of authorities who have commented on benefits sick children obtain from the presence of their mothers.^{2,3} It is interesting to note that in England, at present, the great majority of hospitals allow unlimited visiting and have expanded rooming-in facilities.⁴ This change resulted from the support of the Ministry of Health⁵ and the efforts of a private organization called "Mothers Care for Children in Hospitals."⁴ The increase in unlimited visiting of hospitalized children by their parents has been much slower in the United States. As early as 1963, 15% of the hospitals with approved pediatric residencies allowed parents to stay overnight with their hospitalized children.⁶ A number of recently built pediatric facilities provide for rooming-in facilities for parents of hospitalized children.

The Hospital Care Committee also favors the liberalization of visits of hospitalized parents by their well children. Most hospitals in Illinois prohibit children under 12 years of age from visiting parents in the

Table 2
Visiting in 83 Hospitals with Limited
Visiting in Pediatric Departments

	Unlimited Visiting of Critically Ill Children	Unlimited Visiting of Emotionally Upset Children	Unlimited Visiting of Child With a Psychiatric Disease	Unlimited Visiting on Written Order of Physician
Allowed	80	62	58	71
Allowed in Private Room only	1	1	1	1
Not Allowed	1	18	11	9
Question Unanswered	1	2	—	2
Patients Not Admitted For Psychiatric Disease	0	—	13	—

Table 3

Overnight Facilities for Parents Staying with Hospitalized Children

	Overnight Facilities for Parents before 1961	New Over-night Facilities installed since 1961	New Over-night Facilities planned for
Allowed or Planned	43	10	20
No Facilities or Planned	53	96	81
Only in private rooms	10	—	—

hospitals. This is in accordance with the recommendations of the Illinois Hospital Licensing Act and Requirements passed by the Legislature in 1955. It is interesting that the Children's Hospital of the East Bay in Oakland, California, has departed from their policy with interesting results.⁷ This hospital encourages visiting by children of nearby nursery schools and such children are given a tour of the hospital. Children who are subsequently hospitalized appear to adjust more readily to the hospital.

What can be done to encourage additional liberalization of visiting hours for hospitalized children? Pediatricians, general practitioners, surgeons, nurses and hospital administrators and interested parents should urge their hospitals to liberalize visiting procedures in the respective pediatric departments. Architects, administrators and hospital planners should consider having more private rooms with rooming-in facilities for parents and children in planning new additions to existing pediatric departments or new hospitals.

Conclusions:

1. In Illinois a significant percentage of the hospitals (21.7%) have unlimited visiting by parents for their children according to the 1967 survey in com-

Table 4

Visiting Policies in 106 Hospitals On Children Visiting Hospitalized Parents

Visiting under 16 not allowed	84
Visiting allowed to Children 14 or under	1
Visiting allowed to Children 12 or older	8
Infants not allowed	2
No Restrictions	5

parison to only 3.7% in 1961.

2. The average length of time allowed for visiting children in hospitals among those with limited visiting privileges has increased from 3.5 hours to 5.9 hours.
3. Unlimited visiting was allowed in a majority of hospitals if the child was critically ill or emotionally upset.
4. Only a small number of hospitals allow children under 16 to visit hospital patients.
5. The Hospital Care Committee of the Illinois Chapter of the American Academy of Pediatrics favors the extension of visiting privileges to parents of children and the provision of more room-in facilities for parents

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Family Planning Film

A three-part patient education filmstrip series about family planning is presently available from National Health Films, Atlanta, Ga. The series, entitled "Planning Your Family," is designed for use by public health and clinic nurses, social workers,

and others to assist them in discussions about birth control. It is a complete and comprehensive teaching aid which is suitable for individuals with limited educational achievement. Contact: National Health Films, Box 13973, Station K. Atlanta, Georgia 30324.

Rx Products Index

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Hormones' Effects on Salt Retention Studied

A study of the effects of sex hormones on the body's handling of salt and water will be carried out by Dr. Fred H. Katz with the support of a \$20,000 grant from the Population Council of Rockefeller University. Dr. Katz is associate professor of medicine at Loyola University Stritch School of Medicine.

Female sex hormones have long been thought to cause water retention, such as is noted in various stages of the menstrual cycle. Recent evidence, however, indicates that their direct effect on the body may be to cause an excretion of salt, according to Dr. Katz. In response, the body may compensate by increasing the production of aldosterone, the major salt retaining

hormone of the adrenal gland. This compensation may be excessive, resulting in a net retention of salt and water, he said.

Dr. Katz will administer the female sex hormones estradiol and progesterone to normal individuals and study effects on salt and water excretion as well as the levels of renin, a kidney enzyme which mediates the production of adrenal aldosterone secretion.

In addition, Dr. Katz will investigate the effect of the male sex hormone, testosterone, about which little is known in relation to salt and water levels. Recent evidence indicates that this hormone may also cause a loss of salt to the body as a direct effect, he said.

Clinics for Crippled Children Scheduled

Twenty clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Division will conduct fourteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social, and nursing service. There will be five special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

June 4—Hinsdale—Hinsdale Sanitarium
 June 4—Carmi—Carmi Township Hospital
 June 5—Lake County Cardiac—Victory Memorial Hospital
 June 5—Effingham General—St. Anthony Memorial Hospital
 June 10—East St. Louis—Christian Welfare Hospital
 June 10—Peoria General—Children's Hospital
 June 11—Alton Rheumatic Fever & Cardiac—Alton Memorial Hospital
 June 11—Champaign-Urbana—McKinley Hospital
 June 12—Springfield General—St. John's Hospital
 June 12—Rockford—St. Anthony Hospital
 June 13—Chicago Heights Cardiac—St. James Hospital

June 13—Evanston—St. Francis Hospital
 June 17—Belleville—St. Elizabeth's Hospital
 June 18—Chicago Heights General—St. James Hospital
 June 19—Elmhurst Cardiac—Memorial Hospital of DuPage County
 June 19—Bloomington—St. Joseph's Hospital
 June 24—Peoria General—Children's Hospital
 June 25—Springfield Cerebral Palsy—Diocesan Center
 June 25—Aurora—Copley Memorial Hospital
 June 27—Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

CHROMOSOME DAMAGE STUDIED

A project is being established at The University of Chicago to discover if there is a relationship between chromosome damage and drug intake.

The research involving the establishment of an experimental system in animals will be supported by a \$68,549 two-year grant by the Pharmaceutical Manufacturers Association Foundation, Inc., Washington, D.C.

Research will be conducted by Anthony P. Amarose, Ph.D., assistant professor, and James L. Burks, M.D., assistant professor, in the Dept. of Obstetrics and Gynecology of The Pritzker School of Medicine

at the University. The project will be carried out in the research facilities of the Chicago Lying-in Hospital of the University.

Dr. Amarose explained that chromosomes can be damaged by a number of external and internal agents. "A major objective of this study," he said, "will be to measure the response of the cells to drug stimuli and the manner in which the body handles affected cells with chromosomal aberrations."

Lymphocyte cells in the blood stream, and the cells of the bone marrow will be studied.

Illinois Department Of Public Aid**Payment Procedures and Policies Explained**

HAROLD O. SWANK, DIRECTOR
ILLINOIS DEPARTMENT OF PUBLIC AID

Part VII of a Series

The Illinois state budget for fiscal year 1970 (July 1, 1969 through June 30, 1970) was submitted to the 76th General Assembly by Governor Richard B. Ogilvie on April 1, 1969.

The Department of Public Aid's portion of the state budget totals \$676 million, an increase of \$124 million over the requirements of fiscal 1969. More than 90 percent of the amount requested is earmarked for payments made to or in behalf of recipients. The \$676 million sub-divides into about \$60.5 million for operations and about \$615.3 million for grants-in-aid. Federal matching funds are estimated to be about 44 percent of the total, or some \$298.7 million.

**DO YOU HAVE A
GROUSE**

*concerning the
Illinois Department of Public Aid?
This is the place to air it.*

Send to:

IDPA Editor
Illinois State Medical Society
360 N. Michigan Avenue
Chicago, Illinois 60601

Much of the higher requirement is traceable to caseloads which have been rising since the fall of 1967, greater utilization of services, and to persistent increases in rates and charges. Thus, the major budget increases over fiscal 1969 are in the distributive field—that is, grants, goods and services for or in behalf of recipients. The

major segment of the increase is for Medical Assistance, up \$70.1 million, followed by Aid to Dependent Children, up \$38.5 million, education and training for adult recipients, up \$7.4 million, and Aid to the Aged, Blind or Disabled, up \$1.2 million. However, General Assistance requirements are expected to be down by \$0.7 million.

The rising Public Aid budget, while a matter of concern, is at a pace much less than that experienced in other populous states, especially industrial states such as California and New York.

Illinois' assistance grants, though not the very highest in the nation, nonetheless are comprehensive, having been arrived at through studies made by persons trained in such fields as nutrition, finance, marketing, health and welfare. Food and clothing allowances are geared to the cost-of-living index and there have been a number of rises, in increments of three percent, in recent years.

A number of factors have contributed to rising caseloads sustained in Illinois over the past twenty months or so. Frequent publicity in the press plus the direct efforts of welfare groups (associations, unions, churches, OEO Community Action programs) have combined to inform low income individuals and families about welfare eligibility standards and to encourage more and more of them to apply for assistance. This is borne out by the fact that two-thirds of the ADC cases approved (added) in December, 1968, and January, 1969, had never before received public aid.

Another factor contributing to increased caseloads is the federal injunction which since mid-February, 1968, has nullified enforcement of the state's requirement of one year's residency as one condition of eligibility to receive assistance. During the period February, 1968, through March, 1969, there have been added some 3,900 cases in which state residency at the time of application had been less than one year. Undoubtedly many of these "migrant" cases were attracted to Illinois because of better welfare programs. Illinois and some other states are urging the federal government to establish national minimum standards of eligibility and benefits.

Also contributing to caseload increase is the high incidence of fathers and putative fathers who desert their families or otherwise avoid their support responsibilities.

In the 1970 budget is the sum of \$3.3 million to research welfare problems to develop solutions and/or improvements. Illinois has been innovative in the past through special studies and demonstration (or pilot) projects which later have often been emulated nationally.

The \$3.3 million budget for research and development—the first in the Department's history—will be used to test some thoughtfully conceived but as yet untried welfare concepts, and to refine aspects of other pro-

grams in which preliminary testing has uncovered promising leads for improvement. These areas include: employment of sub-professionals to handle much of the routine administration of individual cases, thus freeing the professional caseworker to perform rehabilitative services to individual recipients; services to former recipients and potential recipients to attack problems which, if not solved, likely will cause them to seek public aid within six months; expansion of preventive medicine programs, coordinated with the Department of Public Health, for pre-school children of ADC families; direct financial participation by IDPA to see that ADC children are provided free a daily school lunch; improved adult education and job training programs for adult, able-bodied recipients with greater incentives to attend regularly; and improved procedures to locate deserting fathers and to cause them to support their dependents.

As to the last point there is good evidence that 85 percent of the increase in ADC has resulted from the proximate factors of desertion, separation, and unwed motherhood.

Note that the foregoing data and discussion concern the fiscal 1970 budget estimate, and is not yet an appropriation. However, IDPA recently received a \$110 million deficiency appropriation to meet obligations in the current biennium.

Clip and mail to:

IDPA Editor
Illinois State Medical Society
360 North Michigan Avenue
Chicago, Illinois 60601

QUESTIONS AND COMMENTS CONCERNING Illinois Department of Public Aid

For your convenience in making comments, this space is made available. Please clip and mail with your inquiry noted hereon. Please use this to help the department establish a cordial and workable relationship with the Illinois physician.

Optional

(name)

(address)

(city)

(ZIP)



Membership Forum

March 24, 1969

Dear Doctor Thomsen:

I call your attention to an item on page 347, in the March, 1969 issue of the *Illinois Medical Journal*. This is in reference to the Preceptorship Program.

What is stated is quite accurate except for the fact that (1) this program is officially known as The Chicago Medical School-DuPage County Medical Society Preceptorship Program and (2) The Chicago Medical School obtained the Family Health Program Grant with the help of the Illinois Academy of General Practice. Other funds, still needed, were obtained by many others within the program.

In addition to our own students, one from Loyola University is currently enrolled in the Program, and one from Northwestern will be participating next year. We hope to have a total of 12-15 involved during this academic year, about 18% of the fourth year class.

Sincerely,

LeRoy P. Levitt, M.D.

Dean, Chicago Medical School

What Do You Think?

An Associated Press story out of Washington, D.C., quotes Democrat Senator Gaylord Nelson of Wisconsin as saying that the public is being gouged on drug prices because doctors have been brainwashed by pharmaceutical manufacturers.

What do you think?

Comments should be no longer than 250 words and must be signed. The *Journal* reserves the right to edit any material which is published.

Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.

AFL-CIO MAY OFFER LEGISLATION FOR NATIONAL HEALTH INSURANCE PROGRAM

The push for a national health insurance program may be joined by the AFL-CIO, which now is considering introduction of health insurance legislation. The United Auto Workers already has announced its intention to press for enactment of a national plan and has established a Committee for National Health Insurance with headquarters in Washington, D.C.

According to Bert Seidman, director of the AFL-CIO department of social security, the program now being considered would cover hospitalization, physician services, extended and custodial care, home health services, outpatient and inpatient psychiatric services, eye examinations and prescriptions, and preventive health services provided either through comprehensive group practice plans or through community multiphasic diagnostic centers. The program would be financed under Social Security, with employer, employee, and government each paying a third of the cost. Coverage would be universal, including, in addition to the working population and their families, the unemployed, students, and those on public assistance.

The program that the AFL-CIO is considering, Mr. Seidman said, "would not tolerate sky's-the-limit doctor fees and . . . would insist on both controls and incentives for moderating hospital charges." In addition, it would provide for negotiation of physician fee schedules and hospital charges "instead of present arrangements which largely permit providers to determine their own compensation." (*The Week . . . for Hospitals*, AHA, Vol. 5, No. 12, Mar. 21, 1969)

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

BY JAMES R. SLAWNY AND JOSEPH LOTHARIUS

Veil of Secrecy Surrounds Expanded UMW Insurance Plan

The United Mine Workers of America told ISMS to mind its own business last month when your State Medical Society requested clarification of a questionable agreement UMW sought to extract from our physicians. The agreement—mailed to MDs for their signature without any explanation—appears to bind union members only to participating doctors, thus prohibiting the patient free choice of physician. For a clarification of the agreement—and more information on UMW's newly-expanded medical plan—physicians asked ISMS to intervene. Unfortunately, the union refused to provide any information to ISMS because it prefers dealing with the individual physicians with whom "very satisfactory relationships have been maintained" according to UMW. ISMS is puzzled by the veil of secrecy thrown over the UMW plan.

Dissatisfied MDs Encouraged to Contact UMW Representative

Meanwhile, UMW Area Medical Administrator Dr. George M. Brother encouraged physicians who have complaints or questions about the program to contact him at the UMW Welfare and Retirement Fund office, 34 North Brentwood Blvd., St. Louis, Mo. 63105.

Illinois Physicians Cooperate In Signing IDPA Agreements

Over 4,000 Illinois physicians have signed and returned the Illinois Department of Public Aid agreement sent to them in March. IDPA Director Harold Swank reminds doctors that without a signed agreement in his files, IDPA cannot honor physician billings. This restriction is contained in recent amendments to the Social Security Act. Future MD participants in IDPA programs will be sent the agreement after submitting their first bill.

Fulton Doctors Endorse Hospital Nursing Schools

Fulton County Medical Society has submitted a resolution to the 1969 ISMS House of Delegates endorsing hospital-oriented diploma schools as the preferred medium of basic nursing education in Illinois. The resolution also urges ISMS to oppose efforts to transfer this educational function to a junior college or university.

(Continued on page 608)

practice management **NEWS**

A Service of the Public Relations and Economics Division

BY MARIAN THIELE

INTRODUCTION

The physician who fears he's being left behind in a rapidly changing world may be intrigued by the new "modern" services available through computer billing. Up-to-date? Yes. But a solution to EVERY physician's bookkeeping problems? Not by any means. To discuss the pros and cons of computer billing, the Division of Public Relations and Economics interviewed Robert P. Revenaugh, Vice President of Professional Business Management, Inc., Chicago, and immediate past president of the Society of Professional Business Consultants. Mr. Revenaugh's firm does not provide computer billing service, but is engaged in advising doctors on the business side of their practice.



Robert P. Revenaugh

COMPUTER BILLING NOT FOR ALL, WARNS THIS BUSINESS ADVISER

Mr. Revenaugh, just what is a computer billing service and how does it work?

It's billing done by computer, just as the name indicates. This service is also known as electronic data processing (EDP). The physician's statements are changed into numerical codes. The patient has a code number, as does each procedure and each form of payment, such as cash, check or insurance payment. These numbers are fed into the computer, which then prints itemized bills. Now, this is the very minimum amount of service done by computer billing.

What other services are available through the computer?

Well, depending on the doctor's needs, he can request a weekly total of charges and payments; monthly total of patients seen; diagnoses made and surgical procedures performed; and age analysis to show which accounts are delinquent.

Followup letters printed by the computer can be mailed directly from the outside billing service to late-paying patients. If there are 6, 20 or 30 physicians in a group, their individual production records can be separated by physician to show their activity. This is quite important when a group bases the remuneration of its members on their productivity and when it needs activity information upon which to base business management decisions.

How can a physician determine if his office needs EDP?

First of all, he should determine how much it costs him NOW to bill patients. Then he should examine his reasons for wanting computer billing and determine whether it will solve his problem. Finally, he should determine the cost of computer billing and decide whether the cost is "justified."

The physician with a large volume of billing—such as a GP or pediatrician, who itemizes bills extensively—is a candidate. However, some specialists—such as orthopedists, anesthesiologists, or radiologists, who usually bill a patient for only one service performed—probably would not find EDP very practical. I can think of only one instance whereby these specialists could benefit from EDP . . . if they're hospital-based and have very little office space or management experience. Computers can substitute for a bookkeeper and eliminate having a doctor-on-call chase half-way across town from office to hospital to manage accounting duties.

What adjustments should a physician expect to make in his routine if he changes to computer billing?

He should be prepared to lose control of accounting records because his patients' financial cards will be kept outside the office. Aides refer to last month's statement and track down current balances from there. He must also be flexible enough to sacrifice old ways to fit computer requirements . . . like using certain forms, giving legible accurate information, notifying the computer service when he plans to reduce bills.

Most important, the doctor should be willing to cooperate with the service representative—after all, he's the important "human element" that makes EDP work. The first few months are usually very rough for the physician. If he can't understand the information cranked out by the computer, then it's useless. The representative is the "interpreter" between man and machine.

Having this representative sounds like an important requirement. What others should a physician look for when selecting a computer service?

Well, the company should be local because statements are often mailed directly from the computer site. And if a patient has to call the company for some reason, he doesn't appreciate paying for a toll call. The company should be at least two years old.

It should also be:

1. Knowledgeable about the inner workings of doctors' offices.
2. Large enough to be staffed with representatives who can teach the physician and his aides the proper

way to use EDP.

3. Flexible enough to adapt to the physician's routine.

4. Willing to discuss cost openly.

How are charges usually set, Mr. Reve-nough?

There's no consistency in pricing—it's like comparing apples with oranges. Some EDP services charge each time data is fed into the computer. Others charge per statement, a range all the way between 22 cents and \$1.75. Some charge for stationery, others don't. Some include installation and charge 10 to 15 cents per account for conversion. But to give an approximate idea, the cost will probably be about 5 percent of the doctor's gross receipts.

What do you mean by "conversion?"

The time spent changing over from the physician's old billing system to computer. This is usually done over a weekend . . . a Wednesday or Thursday . . . or when the doctor is out of the office. The representative collects patients' names, balances, names of insurance carriers, etc., and transmits the information to the computer.

Is the physician expected to sign a contract?

No, but the computer service usually expects clients to stay on for at least six months to allow time to iron out the "bugs." This is true especially if no conversion fee is charged.

What effect does computer billing have on collection ratio?

A very good one, we've learned. Collection ratio can be increased to as high as 95 percent using a computer. EDP can help improve followup methods by regularly furnishing reports on delinquent accounts 60 or 90 days old. Some services supply reminder forms and even addressed return envelopes.

Of course, the computer cannot be a cure-all for collection problems when poor office systems prevail. The physician still must charge fair fees, bill promptly and regularly, and file insurance forms properly. All these practices dovetail to produce a good collection ratio. If the doctor uses computer billing, it is advantageous to have the service performed by a company specializing in accounts receivable management rather than a company which performs merely a mechanical processing of bills.

(Continued on page 608)

Medical School Curriculum Should Include Course in Patient Care Costs

Rising health care costs prompted the DuPage County Medical Society to submit a resolution to the 1969 ISMS House of Delegates that would require a course in patient care costs be made part of the curriculum in all Illinois medical schools.

+++++

Suggest COMSTAT Type Structure for Health Insurance Carriers

The ISMS House of Delegates will be asked to encourage private health insurance carriers to form a COMSTAT type of national health corporate structure to provide health care financing to the country. The Chicago Medical Society resolution also asks that physicians be paid on a usual and customary fee-for-service basis. Should any profits accrue from such corporate structure, it is suggested the profits be distributed among the medical schools now in existence, or contribute to the badly needed new medical school program.

YOUR ISMS INSURANCE QUESTIONS:

QUESTION: At what age are self-employed physicians eligible for retirement benefits?

ANSWER: Under the Retirement Investment Program, members are eligible to receive benefits at any time. Under the laws governing the Keogh Tax-Qualified Retirement Program, an owner-employer may withdraw his funds for any reason after age 59½ and must begin withdrawal no later than age 70½. However, Keogh benefits may be paid at any time in the case of total disability and are payable immediately in the case of death. The law provides severe restrictions and penalties for self-employed physicians making withdrawals before age 59½ unless totally disabled. On the other hand, an employee quitting his employer before age 59½ may make full withdrawal without penalty and also receive capital gains treatment.

Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Ill. 60601. The column is a service of the ISMS Committee on Medical Economics and Insurance.

Practice Management News

(Continued from page 607)

How does EDP help with Medicare and insurance billing?

The computer can automatically fill out most of the claim form, except such items as hospital dates and diagnosis. Also, for faster payments, tapes can be transmitted directly to the insurance company, eliminating the step of printout by the computer the physician's using. Not too many services presently prepare insurance forms. But when the "bugs" are worked out, this by-product of computer billing may be the

answer to the doctor's paper-work overload. **Doesn't the use of computer billing tend to depersonalize one's practice?**

Not necessarily. Let me assure the physician expressing this fear that communication by numbers exists only between himself and the computer. The doctor himself is still responsible for sending accurate information to the machine. Remember, the computer is only a tool with a long memory and a facility for spewing out its data quickly.

NEW

PHARMACEUTICAL

SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

COMBINATION PRODUCTS

AEROSEB-HC Corticoid—Local R

Manufacturer: G. S. Herbert Laboratories
(Div. Allergan Pharmaceuticals)

Composition: Hydrocortisone alcohol 0.5%
Hexachlorophene 0.5%
Isopropyl myristate —

Indications: Seborrheic dermatitis on the scalp and associated scalp conditions.

Contraindications: Tuberculous, fungal and most viral diseases of the skin.

Dosage: Apply locally, once daily.

Supplied: Aerosol bottles with applicator, 30 gm.

BARSEB Derm. Prep.—Other o-t-c

Manufacturer: Barnes-Hind Laboratories

Composition: Salicylic acid 2%
Isopropyl alcohol 45%
Isopropyl myristate —
Propylene glycol —

Indications: Keratolytic treatment of seborrhea.

Contraindications: None mentioned.

Dosage: Apply locally, once or twice daily.

Supplied: Plastic squeeze bottles, 4 oz.

BARSEB-HC Corticoid—Local R

Manufacturer: Barnes-Hind Laboratories

Composition: Hydrocortisone 1%
Isopropyl alcohol 45%
Isopropyl myristate —
Propylene glycol —

Indications: Seborrheic dermatitis of the scalp, or other hairy and intertriginous areas.

Contraindications: Tuberculous and viral infections of the skin, specially herpes simplex, vaccinia and varicella.

Dosage: Apply locally, once or twice daily.

Supplied: Plastic squeeze bottles, 2 oz.

NEW DOSAGE FORMS

NEUTRALOX Tablets Antacid o-t-c

Manufacturer: Lemmon Pharmacal Co.

Composition: Dried aluminum hydroxide gel 300 mg.
Magnesium hydroxide 150 mg.
Magnesium trisilicate 150 mg.

Indications: Gastric hyperacidity.

Contraindications: None mentioned.

Dosage: One or two tablets 1-3 hrs. after meals and at bedtime.

Supplied: Tablets, chewable—multiflavored, bottles of 100 and 450.

POLYICILLIN Tablets Antibiotic—Penicillin R

Manufacturer: Bristol Laboratories

Nonproprietary Name: Ampicillin trihydrate

Indications: Infections due to susceptible strains of Gramnegative bacteria: streptococci, pneumococci, and nonpenicillinase-producing staphylococci.

Contraindications: Hypersensitivity to penicillin or cephalosporins. Infections caused by penicillinase-producing staphylococci or other organisms.

Dosage: Adults: 250-500 mg. q.6h. to q.i.d.

Children: 50-100 mg./kg./day in equally divided doses, q.6h. to q.i.d.

Supplied: Tablets, chewable—125 mg., bottle of 40.

The Oath

I swear by Apollo the Physician, by Aesculapius, by Health, by Panacea, and by all the gods and goddesses, making them my witnesses, that I will carry out, according to my ability and judgment, this oath and this indenture. To hold my teacher in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture. I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong doing. I will keep pure and holy both my life and my art. In whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm. And whatsoever I shall see or hear in the course of my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets. Now if I carry out this oath, and break it not, may I gain forever reputation among all men for my life and for my art; but if I transgress it and foreswear myself, may the opposite befall me.—Hippocrates—Translation by William Henry Rich Jones (1817-1885).

THE RESPONSE GAP



Five South American Medical School Libraries

BY PAUL S. AMOS/CHAMPAIGN

Five South American medical school libraries—in Argentina, Uruguay, Brazil, Peru, and Panama—are considered as to books, journals, classification and cataloguing, and administration.

Buenos Aires has the largest collection of books. The library in Uruguay is recovering from a fire. The library in Brazil is divided between Didactic and Advanced sections. The libraries in Peru and Panama have small collections, but they are making extra efficient use of them.

All these medical school libraries subscribe to a fair number of journals, but the library in Lima, Peru is especially outstanding in this regard for it receives 900 periodicals.

In classification and cataloguing these five medical school libraries have followed U. S. models.

Only the medical school library at the University of Buenos Aires is headed by a physician; the other libraries are administered by librarians. Though their incomes are limited, all these libraries seem to be well-managed.

Paul S. Amos is Librarian for the Adler Zone Center, Champaign. Mr. Amos holds an M.S. from the Columbia University School of Library Service, as well as an M.A. from the University of Chicago. He has also served as librarian of the Worcester Foundation for Experimental Biology and research librarian of S.B. Penick & Co.



On a recent six-weeks trip to South America I visited five medical school libraries: the University of Buenos Aires, the University of the Republic in Montevideo, Uruguay, the University of Rio de Janeiro, the Medical Faculty "San Fernando" in Lima, Peru (where students continue after two preliminary years at San Marcos University), and the University of Panama.

Which medical school libraries are best fulfilling their overall purpose? My general impression was that the medical school libraries in Peru and Panama are most aware of the medical needs of the people of their countries. In Peru there is malaria in the mountains and the jungles and leprosy near Iquitos. The Medical Faculty "San Fernando" is responsive to these problems. In Panama there is considerable tuberculosis and hookworm; the medical school library at the University of Panama seems well aware of these facts.

In all five of the medical school libraries there perhaps could be a higher proportion of material in the vernacular—in Spanish and Portuguese. For example, neither the medical school library of the University of the Republic in Uruguay nor that of the Medical Faculty "San Fernando" in Peru had the Merck Manual in Spanish.

In all five medical school libraries there seems to be much reliance on U. S. indexes and other reference books. All these libraries have such tools as our Index Medicus, The Current List of Medical Literature, and The Quarterly Cumulative Index Medicus.

In each medical school library I found an eagerness to learn and to serve, but in each case the financial resources are not unlimited. For instance, the University of

Panama Medical School Library binds back journals when they have the funds.

What of the bookstock in each of these medical school libraries? Certainly the University of Buenos Aires is relatively well equipped with more than 550,000 volumes.¹ The Library of the Faculty of Medicine of the University of the Republic of Uruguay with more than 200,000 volumes² is not as complete in books, but there is a reason for this. Recently they had a disastrous fire, but they are since trying valiantly to rebuild their collection. They have a Reserve System for newer medical books which makes for efficient use.

At the University of Rio de Janeiro, where the medical books amount to over 85,000 volumes,³ the Medical School Library is divided into a Didactic Library on the first floor and the Advanced Library on the fourth floor. The textbooks are in the Didactic Library, while the more advanced research material is upstairs. Noted in the Didactic Library were such books as Golden's Diagnostic Roentgenology, Friedberg's Diseases of the Heart, and Luisada's The Heart Beat. Also kept in the Didactic Library is an English-language edition of The Merck Manual. In fact, there is considerable English-language material in both the Didactic and the Advanced Library.

At the "San Fernando" Medical School Library in Lima there are about 50,000⁴ books and bound journals. This is not a large collection by U. S. medical school standards, but the collection seems to be well-organized and is kept up-to-date by a Library Committee consisting of a President and two professors and two delegates appointed by the medical students. In this way the library keeps current not only in texts and monographs, but also in such reference books as Spanish and English-language medical dictionaries.

Recently this library has received a \$10,000 grant from the Kellogg Foundation which they have spent on new medical books.

In Lima the library maximizes the efficiency of its collection by keeping new editions in the library for reference. Also the library of the Medical Faculty "San Fernando" in Lima gets increased mileage by allowing textbooks to be lent for just three days and reserve books overnight.

The library uses separate shelves for new books—quite a number of these are in English. These medical texts run the whole gamut of specialties from anatomy to urology.

At the Medical School Library at the University of Panama the total book collection is only about 25,000 volumes,⁵ but there is considerable reliance on the medical encyclopedias. Of course, there are numerous texts on the shelves—in biochemistry, genetics, histology, pathology, pharmacology, public health, and in other fields. The University of Panama Medical School emphasizes cardiology and geriatrics. They try to meet local needs by paying considerable attention to tuberculosis and hookworm. However, they are not much concerned with schistosomiasis which seldom, if ever, occurs in Panama. Of special interest are books on psychiatry—under a new social plan Panama is attempting to treat its mental patients sooner before their problems become too acute.

The Medical Library at the University of Panama has segregated its old books in a special section for books 25 years or older. The University of Panama also has in English the yearbooks in all major medical fields.

In regard to journals, all five medical school libraries use a Kardex. In reference to journals let us consider the individual libraries. The University of Buenos Aires seems well-supplied with medical journals: for example, they have *Lancet* right back to the very beginning in 1823.

At the University of the Republic in Uruguay the Kardex is divided by category—English language, Latin American, etc. They have medical journals from all over the world.

At the University of Rio de Janeiro such research tools as *Chemical Abstracts*, *British Abstracts*, and *Analytical Abstracts* are kept in the Advanced Library. Also both the Kardex and the journals are kept on the fourth floor.

However, in their Kardex the journals are not arranged by language (as in Uruguay). At the University of Rio are an interesting collection of medical journals—journals relevant to the problems of Brazil. For example, they have both *The Journal of Parasitology* and *The Annals of Tropical Medicine and Parasitology*.

(Continued on page 618)

The AMBAR
SCRAPBOOK
of

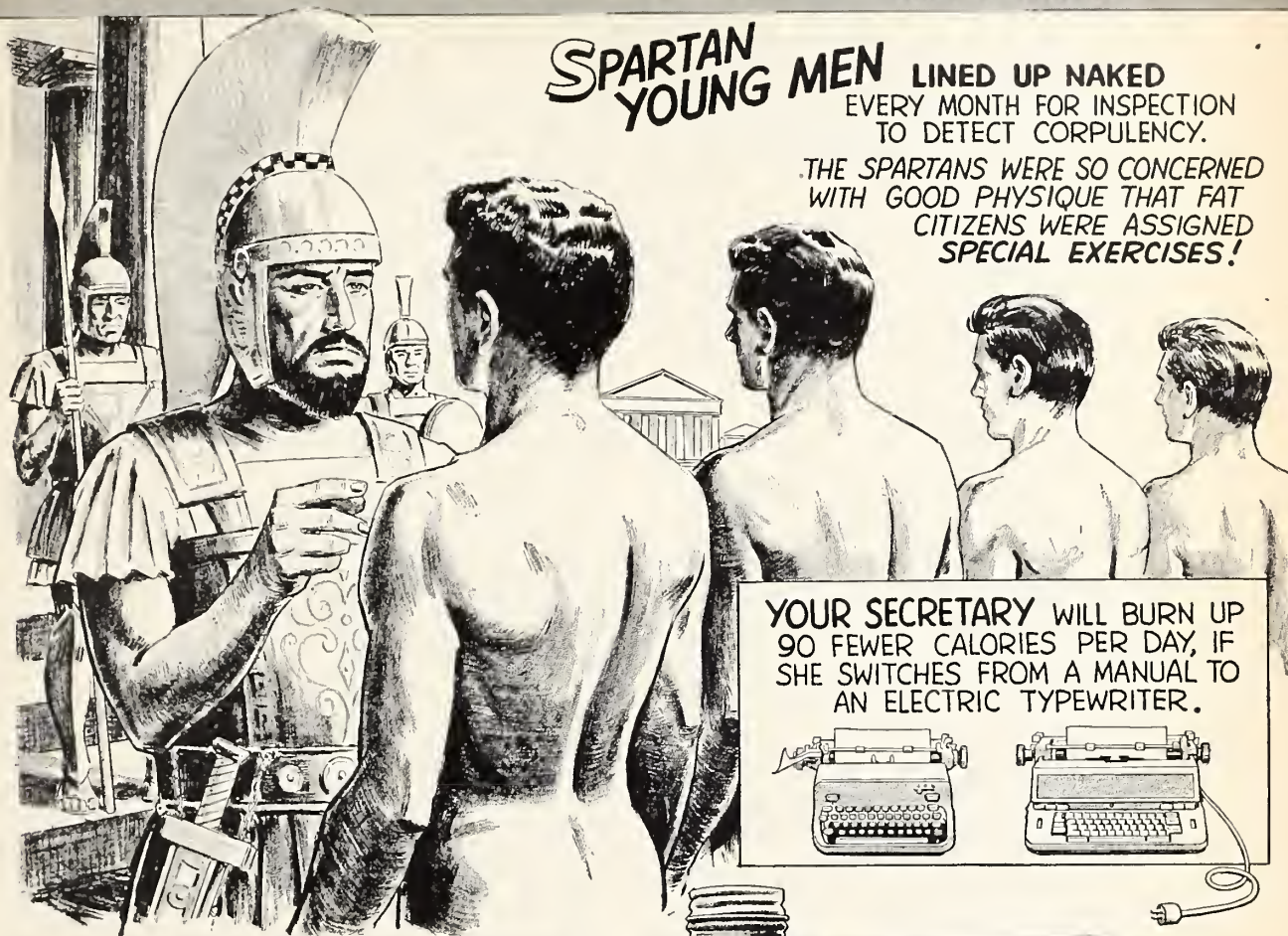
Obesity Oddities

FACT & LEGEND

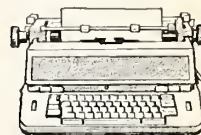
SPARTAN YOUNG MEN

LINED UP NAKED
EVERY MONTH FOR INSPECTION
TO DETECT CORPULENCY.

THE SPARTANS WERE SO CONCERNED
WITH GOOD PHYSIQUE THAT FAT
CITIZENS WERE ASSIGNED
SPECIAL EXERCISES!

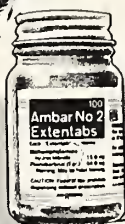


YOUR SECRETARY WILL BURN UP
90 FEWER CALORIES PER DAY, IF
SHE SWITCHES FROM A MANUAL TO
AN ELECTRIC TYPEWRITER.



DIETING IS GREATEST IN THE MONTHS:
JANUARY-FEBRUARY AND MAY-JUNE.

OVERWEIGHT PEOPLE
ARE LEAST
INTERESTED
IN DIET IN
DECEMBER.



THE Cost of
AMBAR EXTENTABS

IS APPROXIMATELY
ONE-HALF THAT OF
OTHER LEADING
APPETITE
SUPPRESSANTS.



AN IMPORTANT FACTOR
IN LONG-TERM THERAPY!

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BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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A-H ROBINS

Medical School Libraries

(Continued from page 616)

At "San Fernando" in Lima the medical journals are arranged alphabetically on the shelves. The library receives 900 periodical titles by purchase, gift, and exchange. This medical school publishes three journals, which it can use for exchange purposes:

1. *Anales de la Facultad de Medicina*, Vol. 1, 1918.
2. *Revista de Ciencias Psicologicas y Neurológicas*, Vol. 1, 1964.
3. *Archivos del Instituto de Biología Andina*, Vol. 1, 1965.

At "San Fernando" although old journals circulate bound, new unbound, current journals circulate to 6th year medical students. In Lima, the library subscribes to all sections of *Excerpta Medica* but they are in English. Pamphlet materials are kept in pamphlet boxes.

At the Library of the Faculty of Medicine at the University of Panama there is considerably more emphasis on journals than on books. Among the periodicals to which they subscribe are *The Annals of Internal Medicine*, *Bioresearch Titles*, and *Federation Proceedings*. Also they have at least some of the *Actas*.

At Panama they have recently acquired a brand new Kardex. But at last report they were still using the old Kardex for journals acquired since 1960. They use an old, old Kardex for journals acquired before 1960.

As in Lima the library of the Faculty of Medicine at Panama subscribes to all sections of *Excerpta Medica* but in English. Most of the medical students read though they may not necessarily speak English.

In classification and cataloguing, U. S. influence is strong in our South American medical school libraries. For example, at the University of the Republic (Uruguay) they use a combination of the Boston Medical and the National Library of Medicine Classification Systems. Their Head Cataloguer has three files for translating the National Library of Medicine *List of Subject Headings* from English into Spanish.

The Didactic Library at the University of Rio de Janeiro uses the Dewey System. The Didactic Library catalogues by author and subject but the Advanced Library on

the fourth floor has a dictionary arrangement of its catalogue.

At "San Fernando" in Lima they use the Cunningham System of Classification. Señora de Cuadra, Head Librarian at "San Fernando," implied a tribute to the National Library of Medicine System but stressed how burdensome it is to shift from one system to another.

In Lima there is also a catalogue of works by author and subject. Recent accessions are kept on cards in a different drawer. Also there is another catalogue for "obras antiguas" which are not kept in the library but in another building. There is also a pamphlet catalogue by author and subject. And "San Fernando" has a thesis catalogue by author and subject. The first thesis dates from 1854.

In Panama there are two catalogues: by author and title and by subjects. They use the National Library of Medicine Classification.

As for personnel, of our five medical school libraries, the situation is mixed. At the University of Buenos Aires the library is headed by a physician. In the other cases librarians are in charge. And the subordinate personnel seem to be mostly librarians by profession. For example, a librarian at the Didactic Library in Rio was a graduate of the Library School at the University of Sta. Ursula (Brazil). In the Advanced Library in Rio one of the librarians had spent a year as an exchange student in California. And there were other occupations on the staffs—especially in Lima where the library employs translators, some of whom are medical students.

SUMMARY

The medical school libraries in Peru and Panama are performing their functions creditably with limited resources. All five medical libraries perhaps should rely more heavily on material in Spanish or Portuguese and less on U. S. material. The University of Buenos Aires is the best supplied with books; the library in Uruguay is recovering from a disastrous fire. The library in Rio de Janeiro has divided its collection between a Didactic and an Advanced Library. The libraries in Lima, Peru and Panama City make an especially efficient use of their small book collections.

All these libraries use a Kardex. Buenos

(Continued on page 625)

MAILING OF BOARD ABSTRACTS APPROVED

Reporting for the Eleventh District, Dr. Joseph O'Donnell recommended that an unapproved summary of all Board of Trustees actions be mailed to all ISMS delegates, county society presidents and secretaries as soon as possible after the meeting. This recommendation was approved.

TIME OF THIRD DELEGATE SESSION CHANGED

Dr. Maurice M. Hoeltgen, speaker, ISMS House of Delegates, reminded the Board of the times of the various House of Delegates sessions at the annual meeting, May 18-21, in Chicago. The House will meet:

Sunday	May 18	3 p.m.
Tuesday	May 20	2 p.m.
Wednesday	May 21	10 a.m.

AMA NOMINATIONS

Dr. William K. Ford, chairman, ISMS Delegation to the AMA, reminded the Board of Trustees that the Illinois Delegation plans to nominate Dr. Walter C. Bornemeier for the office of AMA President-Elect and Dr. Burtis Montgomery to succeed himself as a member of the AMA Board of Trustees, which he serves as chairman at this time.

ISMS HOLDS CONGRESSIONAL RECEPTION

ISMS Executive Administrator, Roger N. White, reported that ISMS recently held a very successful reception for freshman legislators in Springfield. He indicated that a good turnout had ensued and that it was the intention to hold similar events in Springfield in the near future.

MEDICAL-LEGAL COUNCIL REPORTS

Dr. Noel Shaw, chairman of the ISMS Medical Legal Council, reported that the Council will meet with the Chicago Bar Association in the very near future to discuss the establishment of a malpractice screening panel to be utilized in malpractice suits.

MEDICAL EDUCATION COUNCIL REPORTS

The Committee on Continuing Education requested that it be considered as two units, one for downstate, the other in metropolitan Chicago. This was considered an effective way to better decisions in this important area. This committee also received approval to determine voluntary continuing education activities of the membership through mail inquiry. The five medical schools will also henceforth be represented on this committee.

SUMMER JOB-EDUCATION PROJECT PROGRESS

Dr. Gibbs, Council on Medical Education chairman, continued his report indicating that 150 students have expressed an interest in the Summer Job-Education Project, 1969. Several hospitals already have responded with potential programs.

STUDENT REPRESENTATION ON ISMS COMMITTEES

The Council recommended that study and consideration be given to representation on ISMS Councils and Committees for medical students (SAMA) where it is felt the student viewpoint would be valuable to the Society and to the physicians in Illinois.

FILM ON RURAL PRACTICE PROPOSED

The Committee on Rural Health and Student Loan Fund reported that all ten students recommended this year were accepted. It was also indicated that consideration was being given to separating the functions of this committee into Rural Health and Student Loan Fund Committees. The Board approved a request to study and explore the possibility of producing a film portraying and promoting rural Illinois and medicine as it is practiced there.

ESTABLISH GUIDELINES ON ACUTE CARDIAC CARE

Dr. Thomas R. Harwood, chairman, ISMS Council on Public Relations, presented the recently developed guidelines of responsibility for nurses caring for acute cardiac patients. The Board of Trustees approved the guidelines.

BLUE CROSS-BLUE SHIELD REQUESTS DISTRICT CONSULTATION SERVICES

The Blue Cross-Blue Shield Plan of Illinois asked the Board to approve each trustee nominating one physician from his district to serve as a Blue Cross-Blue Shield consultant on a paid per diem plus expenses basis. The Board instructed each trustee to poll his district on this request and suggest possible physicians who might wish to serve in this program at the next Board meeting.

IDPA AGREEMENT

Mr. Harold Swank, director, Illinois Department of Public Aid, appeared before the Board to discuss the agreement form recently sent to all doctors participating in the public aid program. Mr. Swank agreed that the minimum requirements for such an agreement involved keeping of adequate records as are necessary to reveal the extent of services provided to public aid recipients and to furnish the department with the necessary information to substantiate the claim for payment. A revised agreement containing only these items is being developed.

Meeting Memos

May 18-21—Illinois State Medical Society

Annual Convention
"Medicine in the 70's"
Sherman House, Chicago

May 19-20—American Society of Anesthesiologists

11th Biennial Western Conference on Anesthesiology
Hotel Utah, Salt Lake City, Utah

May 21-24—American Society of Anesthesiologists

3rd Annual Symposium on Acute Medicine
University of Pittsburgh School of Medicine
Pittsburgh, Pennsylvania

May 23—The Chicago Medical School & The Illinois Academy of General Practice

Problems of the Family Physician: From Children to the Climacteric
Playboy Club, Lake Geneva, Wisconsin

Medical School Libraries

(Continued from page 618)

Aires, Uruguay, and Rio seem especially well-supplied with journals. However, the Medical Faculty "San Fernando" in Lima receives as many as 900 periodical titles by purchase, gift, and exchange. This medical school publishes three different journals. As is true of the other libraries the Medical School Library at the University of Panama receives not only numerous medical journals but also all sections of the English-language edition of *Excerpta Medica*.

In classification South American medical school libraries follow the U. S. models of the Dewey, National Library of Medicine, Boston Medical, and the Cunningham Systems. These medical school libraries have varied their catalogue arrangements.

The Faculty of Medicine Library in Buenos Aires is administered by a physician; the other medical school libraries have librarians in charge. Although their financial means are limited all these libraries are substantially achieving their purposes.

References

1. Internationales Bibliotheksadressbuch – World Guide to Libraries, Bearbeitet von/Compiled by Klaus Gebhard Saur. Erste Ausgabe 1966, Teil 2. First Edition 1966, Part 2. Munchen-Pullach, Verlag Dokumentation, 1966, p. 707.
2. Guia de Biblioteca de la America Latina, Edition provisional, Union Panamericana, Secretaria General, Washington, D.C., Organizacion de los Estados Americanos, 1963, p. 158.
3. *Ibid.*, p. 5.
4. Internationales Bibliotheksadressbuch, *op cit.*, p. 802.
5. Guia de Bibliotecas de la America Latina, *op. cit.* p. 134.

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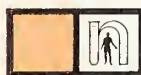
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**ILLINOIS
MEDICAL
ASSISTANTS
ASSOCIATION
REPORT**



"A code of ethics is fundamental to the high standards which characterize I.M.A.A. members. The responsibility to the profession of a medical assistant should conform with honor and dignity of cultured persons. The principles of medical ethics set forth are for the common good of the members and should be observed in such a manner as will merit and receive the endorsement of the medical profession."

There are times, I am sure, when all of us wonder about "How do we rate as a Medical Assistant?" Someone said, "He who stops being better, stops being good." A good medical assistant continually tries to improve her awareness of her executive responsibilities. Changing times and her ability not only to do her own job well but to teach others how to do it is her challenge.

What methods do you use to make a patient feel that you really care for him? Do you ask him how he feels and do you call him by name? Do you really listen to him? Do you reassure him that the doctor will want to know all about his symptoms? Do you say goodbye to him? Do you

express sympathetic kindness to him at all times? Do you let the patient know that your office and its staff not only care for him but *about* him?

Have you ever thought about the amount of tact needed when handling an uncooperative patient? The patient who seems disgruntled and belligerent and uncooperative may be masking fear he doesn't want to show. The patient who doesn't seem to listen actually may be on the verge of hysteria. Great compassion on the part of the medical assistant is needed in helping these individuals.

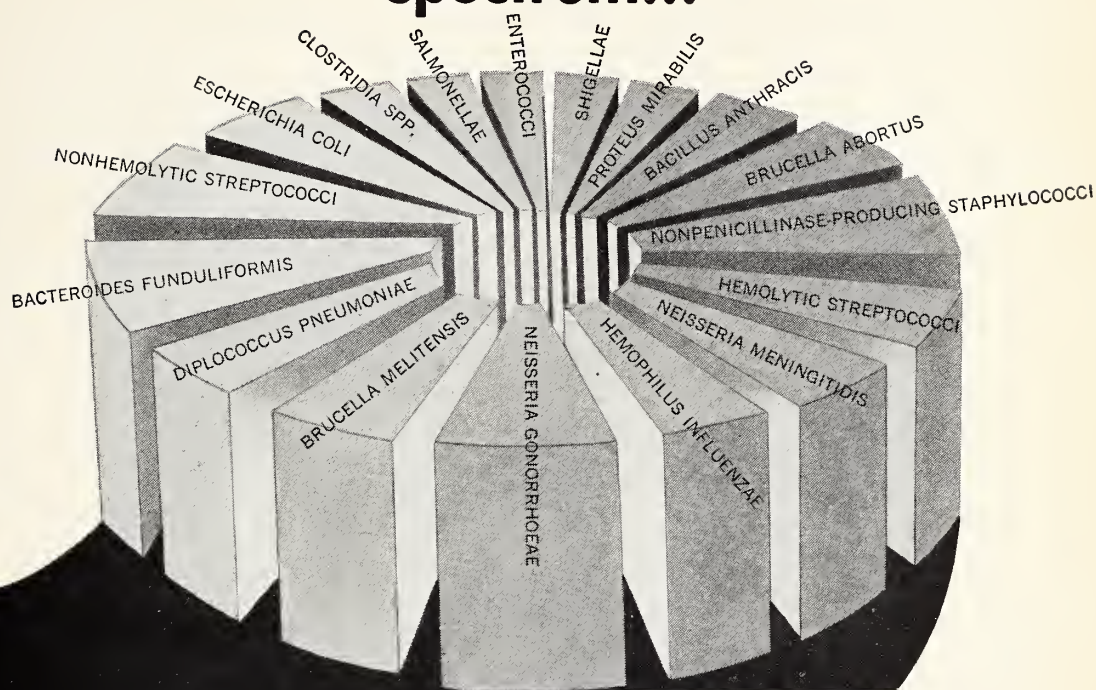
Illinois Medical Assistants hope that all physicians will be so impressed with our organization that membership in the American Medical Assistants Association will be a "must" for office personnel.

Our participation in education, legislation and charitable activities all point to interest in the community in which we live and work. As we enlarge our outlook and broaden our horizons, we have the thrill of being a personal participant in the medical and civic enterprises of our time. This makes for more efficiency and loyalty to our employers.

NURSE DIPLOMA PROGRAMS CONTINUE TO DWINDLE

Continuing the trend of recent years, the number of hospital diploma schools of nursing decreased by 39 during 1968 while 49 new associate degree nursing programs and 14 new baccalaureate degree programs were established, the National League for Nursing reports. At the same time, schools of nursing in the aggregate showed sizable gains in admissions, graduations, and enrollments during the academic year 1967-1968. Admissions to all schools reached 61,389, a gain of 2,689 over the previous year. Enrollments, up 3,640 over the previous academic year, reached 145,588. Graduations also showed a gain—from 141,948 to 145,588—even among diploma schools, which marked a slight increase in graduations despite the decreased number of programs. (*The Week . . . for Hospitals*, AHA, Vol. 5, No. 12, Mar. 21, 1969)

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Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site

and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

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The Story of Public Health in Illinois

By JAMES H. HUTTON, M.D./CHICAGO AND BAXTER K. RICHARDSON/SPRINGFIELD

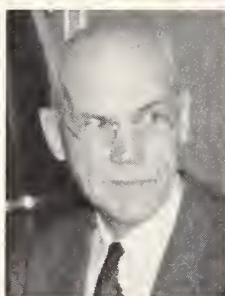
Public health service as a permanent function of the state government started in 1877. In that year, two laws were enacted by the General Assembly and signed by Governor Cullom.

One required the licensing of doctors. Prior to 1877, no license was required. Any one who wished to practice medicine simply hung out his shingle and waited for victims. It was estimated that there were about 3,600 non-graduates practicing in Illinois at the time.

The other created a state board of health and gave it "general supervision of the interests of the health and life of citizens of the state" and the power to make rules and regulations concerning the preservation or improvement of public health, enforceable as law.

There had been other attempts to establish something of the kind. In 1817 the last Territorial Assembly enacted a law which divided the state into two districts, one east and one west of the third principal meridian with a medical society in each. These had what amounted to power to grant licenses. Nothing came of this and in 1819 the first General Assembly passed "an act for the establishment of Medical Societies." This divided the state into four districts and provided that a physician who failed to attend meetings of his medical society without an adequate excuse should be subject to a \$10.00 fine. It also provided that these societies should examine physicians' bills. If any were found exorbitant, the excess was to be returned to the patient. Another Act was passed in 1825. These laws were repealed by the next succeeding session of the General Assembly. Bills were proposed at nearly every session after that.

James H. Hutton, M.D., (above), is an endocrinologist in Chicago. He is past president of the Illinois State Medical Society and Chicago Medical Society, former chairman of the Tuberculosis Control Committee, and co-chairman of the State Eradication Committee. Dr. Hutton received his M.D. from Northwestern University. Baxter K. Richardson is a retired Public Health Administrator. He received an A.B. degree from Haverford College and is the author of "A History of the Illinois Tuberculosis Association."



The delay in giving legal status to a public health program resulted from neither indifference about health nor the lack of compassion on the part of legislators. They simply did not believe the doctors could deliver what they promised and there was a suspicion of selfishness in their attempts. Indeed, there were two factions in the medical profession regarding the proposed law. One thought that the public health would be adequately served if only well trained physicians were allowed to practice, eliminating quacks, charlatans and "medicine men." The other believed that the extension of sanitation and hygienic practices were needed to protect and improve the public health.

Under the circumstances, the politicians were somewhat like Hamlet in reference to the hereafter—they were skeptical about the promises made by the doctors but fear-

ful of the consequences in case they were right. But the politicians knew exactly how to deal with such situations. They passed two laws, satisfying both factions. They made the Board of Health responsible for implementing both and gave it only a token appropriation with which to work. They appropriated \$2,500 per year and allowed the Board to keep the license fees collected, amounting to about \$6,000 a year. Thus the stage was set for launching a new state agency, which in the fullness of time, would stand the people in good stead and reflect credit on the medical profession for its foresight and wisdom in bringing about the establishment of a state public health agency.

State Board of Health Organized

Now it was up to the State Board of Health, organized on July 12, 1877, to justify its existence. Happily the five physicians and two educators appointed to membership on the Board were highly qualified to guide the new agency. Dr. John W. Rauch, who had been Grant's chief medical officer, was elected President of the Board and within six months thereafter, took over as executive secretary.

The job ahead was indeed formidable but Rauch was a formidable man. He had to get all the doctors licensed. He had to do something about the epidemics, especially smallpox, which were widespread in the state. He had two clerks but didn't hesitate to call on members of the Board to lend a hand, especially with registering doctors and rating medical schools. Circumstances soon compelled him to leave matters of registration almost entirely to the clerks and the Board members. A major epidemic of yellow fever invaded the Mississippi Valley in the summer of 1878. Smallpox was a perennial menace. These two menaces to public health demanded of Dr. Rauch his immediate and undivided attention. Both of these diseases, as well as others such as cholera, although their immediate threat was local, Rauch regarded as world-wide problems and believed that epidemic communicable diseases could be effectively controlled in Illinois and in America only by means of a strong, well organized, highly efficient public health agency at the federal, state and local levels, set up to function cooperatively, thus pro-

viding a national system of public health administration.

With yellow fever, which solidified national interest and concern almost as would an enemy military invasion, as his immediate target, Rauch set about converting his beliefs into practical plans. In less than two years he had organized or activated, under the provisions of the Cities and Villages Act of 1872, no less than 50 local boards of health and put them to work on smallpox vaccination campaigns; he had engineered a conference in Chicago of national health authorities which resulted in the inauguration of an Immigration Inspection Service (June, 1882) to prevent the introduction of smallpox from abroad; he had participated in the organization of and been himself elected secretary of the Mississippi Valley Sanitary Council, an agency for collecting morbidity information; he had established close relations with the National Board of Health at Washington.

So successful was Dr. Rauch in these and other similar activities that he was able to report to the Board on January 24, 1882 that "I doubt if the people of any other state, of equal age, are so well protected against smallpox as those of Illinois." On October 3, 1879, with reference to the prevailing yellow fever situation, Dr. Rauch was able to inform the National Board of Health that "I am almost constantly advised by telegraph, no matter where I am, of the condition of affairs throughout the whole Valley, and I am, therefore, in position to judge intelligently of the situation."

These typical performances of Dr. Rauch illustrate his philosophy as well as the character and magnitude of the public health work accomplished during his tenure from 1878 to 1891. He laid down, with Board approval, the principles of administration and established the pattern which public health authorities have followed in Illinois ever since.

New Tools for Health Service

The creation of the state public health agency in 1877 could scarcely have been more timely. A whole avalanche of new knowledge, useful in the prevention and cure of diseases, was about to sweep the civilized world. During the 80's, Pasteur

introduced bacteriology and by 1910 the causative germs of diphtheria, typhoid, cholera, tuberculosis, gonorrhea, syphilis, and several others had been identified. Diagnostic blood and skin tests for syphilis and diphtheria had been developed, as had such curative and preventive biologics as diphtheria antitoxin, diphtheria toxin-antitoxin, typhoid vaccine, antirabic vaccine and anti-luetic drugs. The part played by mosquitoes in the spread of malaria and yellow fever had been brought to light. Methods for the purification of public water supplies and safe disposal had been developed. The use of pasteurization to safeguard milk supplies had been introduced.

Here indeed were the tools with which the able health officer could deliver in public health improvement. All and more than the doctors had ever promised. Now also the "good doctors" theory could be tested against that of broad public health programs aimed at improving health—influencing habits and practices of people generally. It remained for the state health officer to plot a course and devise the administrative mechanics which would utilize to maximum advantage the widening opportunities which would continue indefinitely to unfold at an amazing rate.

Egan Lifts Board's Prestige

After the dynamic Dr. Rauch, nothing of great consequence along these lines took place until Dr. James A. Egan, also a former army officer, became the executive secretary of the Board of Health in July, 1897, where he continued until his death in 1913. Dr. Egan made two outstanding contributions to the state public health agency. He led the legislature into appropriating worthwhile money to the Board. During his tenure the biennial appropriations increased from \$28,000 to \$243,349.25. He also engineered through the legislature a bill which made it the *ex officio* duty of the supervisor, the assessor and the clerk of every township, and the commissioners in nontownship counties, to function as a local board of health responsible for executing the rules and regulations of the State Board of Health. Local boards created optionally by local authorities could function or fall apart at will, but here was a state-wide network of local

officers who were legally obligated to function and thus provided a reliable system of communication and the performance of certain prescribed duties such as quarantine. Dr. Egan also established a system of agencies throughout the state for the free distribution of diphtheria antitoxin and started a public health diagnostic laboratory. He introduced sanitary engineering as an agency function. He contributed substantially toward the enactment in 1908 of the Municipal Tuberculosis Sanitarium Act, the first of what came to be known as the Glackin Laws. Under Dr. Egan the State Board of Health may be said to have attained a vigorous and healthy early adolescent development toward a maturity of full-fledged public health service—awkward and undisciplined, but sturdy and ambitious. The Board was still responsible for the registration of physicians. This absorbed two-thirds of the Board's resources.

Drake Professionalizes State Health Service

Dr. C. St. Clair Drake, urbane, elegant and well versed in the theory and practice of public health service by reason of several years of successful experience with the well organized Chicago Board of Health, rounded out with a professional touch the developmental work of Rauch and Egan. Taking over as state health officer (the official title was Executive Secretary of the State Board of Health) in 1914 the state public health agency came of age under his tutelage. He recognized that the "good doctors" theory, as a cornerstone for an adequate and efficient public health service, was wrong. No one believed more profoundly than he in the importance of well qualified doctors. He knew all too well, however, that nobody went to a doctor for vaccination against smallpox unless driven there by fear of an epidemic or police force. He knew that in spite of antitoxin children died of diphtheria because the doctor wasn't called soon enough. He knew that it was already too late in large numbers of cases when the doctor got a chance to diagnose tuberculosis. So the matter of registering doctors and the matter of operating a public health department would have to be divorced. Dr. Drake saw to it that this was done. The two functions were thereafter operated quite indepen-

dently of one another.

As two public health services, Dr. Drake introduced the budgetary system, organized the various services such as laboratory, engineering, communicable disease control, maternal hygiene, and health education into bureaus, each with well defined duties, and established the practice of employing only fulltime trained personnel—a radical departure from the previous practice of employing personnel on a per diem basis as emergencies and available funds dictated. He succeeded also in bringing about the enactment of a model vital statistics registration law, the first for Illinois.

A great leap forward took place in 1917 when, as part of a general reorganization of the state government, the State Board of Health was abolished by Gov. Frank C. Lowden and the Department of Public Health and the Department of Registration and Education created to carry on the functions of public health service and the regulation of medical practice, respectively. Dr. Drake, whose functional, organizational and budgetary plans had been accepted by Gov. Lowden for the structure of the Department of Public Health, was made the Director thereof, and thus became the first authorized to use the title of State Director of Public Health. All of the powers and duties reposed in the Board were transferred to the Department and elaborated in the newly adopted Civil Administrative Code. The Director, responsible solely to the Governor, was also solely responsible for the policies, programs and activities of the Department. The law authorized, however, a State Board of Public Health Advisors, appointed by the Governor. Through this Board and by direct contact, the various state directors of public health have sought and obtained the advice, counsel, and the cooperation of the Illinois State Medical Society.

In 1918 Dr. Drake established a precedent by accepting money from the Federal government to help finance a public health program. As a war emergency measure Congress had appropriated special funds for combatting venereal disease. To extend the program and spread the work, the money was offered to states which agreed to match the Federal funds, dollar for dollar. In this way, what proved to be a permanent, and generally regarded successful,

venereal disease control program in Illinois was established, although the Federal funds which prompted its inauguration were withdrawn after the end of World War I.

Dr. Drake, able, imaginative and well schooled in the philosophy and practice of public health service, and building on the foundation laid down by his predecessors, brought the Illinois state public health agency to a point of maturity which needed only time and guidance to become a major influence on the prevailing health conditions of Illinois. The basic structure of the agency had been completed with a touch of high professional competence. An appropriation of \$720,810 to the Department of Public Health in 1919, compared with the miserly sums previously doled out to the State Board of Health, is testimony to the growth of the state public health agency in size and favor and to the unusual ability of Dr. Drake.

Success Crowns State Health Work

This is the story in brief of the rise of public health service in Illinois. It remained only for the Department of Public Health to keep up with the parade of events, especially in the fields of medicine, sanitation, bacteriology, immunology, etc. This has been done to a highly successful degree. The U.S. Public Health Service in 1936 came into the picture as a partner of the Department when the first allotment of permanently structured Federal aid funds was accepted by Dr. Frank Jirka, Director of the Department of Public Health. An extensive system of local health departments involving some 65 of the state's 102 counties was erected by the Department under the provisions of a law enacted in 1943. All of these and similar developments, together with the independent erection of municipal health departments which were authorized by the Cities and Villages Act of 1872, have provided Illinois with a state-wide public health service of superior rank. It has operated with outstanding success.

Many downstate cities and Chicago established health departments years before 1877. Cahokia—now East St. Louis—had the first health officer (1799)—Madame Beau-lieu, also the first quarantine regulations. To protect itself against smallpox then

epidemic on the "Spanish side," St. Louis, any one crossing the river was to be fined \$6.00 for the first offense, \$12.00 and 10 days in jail for the second offense and to remain in jail 'till the fine was paid. In 1860, Chicago abolished by city ordinance its Board of Health. It was re-established a few years later after a cholera epidemic.

Up to the mid-20's the public health service in Illinois had made no noticeable impact on the prevalence or mortality from such communicable diseases as diphtheria, smallpox, scarlet fever, typhoid fever, etc. Since that time these and several other diseases, notably poliomyelitis, have practically disappeared. The death rate from pneumonia has been cut to a mere fraction of what it was. The State has treated tuberculosis as different from other communicable diseases. The Glackin Acts of 1908 and 1915 took it out of the jurisdiction of the health department and placed it under sanatorium boards, and on

a local option basis, counties and municipalities might or might not do something about tuberculosis just as they elected. The State would do nothing. It was not until the mid 40's that the State Department of Health under Dr. Jirka entered extensively and effectively into the tuberculosis program. However, public health officers still regard tuberculosis as Chicago's most important communicable disease in spite of the fact that the death and case rates have been reduced to a fraction of what they were 30 years ago.

So great has been progress that the big problems of health departments now are the chronic and disabling ailments of later life. These are being attacked through programs of comprehensive health services aimed at providing the kinds of services needed by individuals. The Illinois Department of Public Health is adapting itself to these changing requirements.

Teaching Medicine at Pritzker School of Medicine

"Since Pritzker School of Medicine is relatively small, the hospital patient material has been adequate for bedside teaching of the junior class as well as the house staff. The senior year, which is almost entirely elective, provides out-patient experience and selected in-patient experience as the needs and interests of the student dictate.

Since all patients are available for teaching purposes, assignment of medical students to patients in the OPD or in-patient services is done on the basis of appropriateness of the patient as a teaching case, and is entirely unrelated to his social or economic status. In fact, each patient is given a short descriptive brochure which explains that we operate a teaching hospital where, as patients, they will be involved in the medical school educational program. Patients are admitted to the hospital from the out-patient department; the emergency room; or directly; and go to private or semi-private rooms. Parenthetically, it is quite impossible for students or house staff to know without specific inquiry which patient is paying full charges and which is partly or wholly free. In most cases, even the attending physician is unaware of the financial status of the patient.

Referral of patients in both the clinics and hospitals has always been easy and frequent. The patients profit from the generous employment of formal rather than corridor consultation. It is also true that consultation provides the physicians with a well-thought-out opinion which also serves as an economical way of keeping him abreast of some developments in areas of medicine in which he may not be expert. In addition, the very free use of consultations assures that staff members will have the opportunity to see virtually all the material pertinent to any special research or teaching interest. Since all consultations are actually seen first by a resident and presented by him to the consultant, the education process extends to medical students and house staff." (Speech by Dr. Leon O. Jacobson, Dean, Pritzker School of Medicine, at the New York Academy of Medicine Conference on Group Practice.)

OBITUARIES

***Dr. Joel P. Blancaflor**, Monmouth, died Oct. 30 at the age of 47. He was a past president of the Fulton County Medical Society.

Dr. Stella Nason Boyd, Downers Grove, died Feb. 24.

***Dr. William Joseph Bryan**, Los Angeles, formerly of Rockford, died Nov. 15 at the age of 72. He served as President of the Winnebago County Medical Society and as medical director and superintendent of the Rockford Municipal Tuberculosis Sanatorium.

***Dr. Andrew G. Bustin**, Joliet, died March 4 at the age of 56. A practicing physician for the past 25 years, he was a past president of the Will-Grundy Medical Society and a member of the Society of Clinical Pathologists.

***Dr. C. Robert Cummins**, St. Charles, died March 12 at the age of 47. He was a past president of the Kane County Medical Society and a past member of the St. Charles Board of Health.

Dr. Robert L. Hass, Urbana, died March 7 at the age of 46. A former assistant chief of the dental health division of the Illinois Dept. of Public Health, he was affiliated for the past six years with the University of Illinois Health Service.

***Dr. Edward C. Jana**, Riverside, died March 10 at the age of 56.

***Dr. John Robert Johnson**, River Forest, died Jan. 5 at the age of 70.

Dr. Walter Johnson, Chicago, formerly of Gibson City, died Feb. 28 at the age of 91.

***Dr. Albert E. W. Jourdan**, Chicago, died Nov. 21 at the age of 88. He was an Emeritus member of ISMS, as well as being a member of the ISMS Fifty-Year Club.

***Dr. Oskar Kreisler**, Chicago, died Nov. 28 at the age of 68.

***Dr. Ernest Oliver Larson**, Chicago, an Emeritus member of ISMS, died Nov. 9 at the age of 71.

***Dr. Newton Deyoe Lee**, Pompano Beach, Fla., formerly of Chicago, died Dec. 13 at the age of 85. He was an Emeritus member of ISMS, as well as a member of the Fifty-Year Club.

Dr. S. J. Lewis, Sullivan, died March 9 at the age of 56.

Dr. Stephan Lyskowski, Alton, died Nov. 17 at the age of 63.

***Dr. Charles Levi Maxwell**, Belleville, retired U.S. Air Force Col., died Oct. 14 at the age of 75. He was a member of the ISMS Fifty-Year Club.

Dr. Alberto Reyes Medina, Elgin, died Oct. 5 at the age of 42.

Dr. Ralph Kennedy Miller, Champaign, died Sept. 27 at the age of 70. He was certified by the American Board of Ophthalmology and the National Board of Medical Examiners.

Dr. Lonis Rose, Chicago, a former police department surgeon, died March 27 at the age of 85.

***Dr. George W. Scupham**, Homewood, died recently at the age of 79. An Emeritus member, he was a member of the faculty, Northwestern University Medical School, and a member of the ISMS Fifty-Year Club.

***Dr. Harry Goff Thomson, Sr.**, Mt. Vernon, died Nov. 5 at the age of 62. He was a past president and past secretary of the Jefferson-Hamilton County Medical Society.

***Dr. Eli L. Tigay**, Ft. Lauderdale, formerly of Chicago, died March 6 at the age of 69.

Dr. George C. Vellender, Park Forest, died March 30, at the age of 49.

Dr. Marcia Lonise Young, Chicago, died Nov. 29 at the age of 81.

*Indicates Member of Illinois State Medical Society.

Hektoen Trustees Elected

At the Annual Meeting of the Board of Trustees of the Hektoen Institute for Medical Research of the Cook County Hospital, held at the University Club of Chicago, on March 28, the following were named

Trustees of the Institute: Reverend John Cortelyou, President, De Paul University, and Dr. Leo Weiner, Director of Hematology, Hektoen Institute and Cook County Hospital, Professor of Medicine and Clinical Pathology, Chicago Medical School.

New Discoveries in Insulin Reported by Chicago Scientists

Discovery of a precursor of insulin may have important implications for the treatment of diabetes and other diseases, scientists at The University of Chicago have found.

They have demonstrated that the two chains of insulin, a protein hormone, are formed as part of a single, larger polypeptide chain which is then transformed to insulin before it is secreted.

According to the project's director, Dr. Donald F. Steiner, Associate Professor of Biochemistry, these experiments directly contradict the previous assumption that the two insulin chains are made separately. He tentatively concludes that the precursor is a preliminary stage in the production of insulin which insures "the assembly of the chains of the insulin molecule with a high degree of precision."

Dr. Steiner reported on the research at a recent meeting of the Federation of American Societies for Experimental Biology.

Proinsulin, the name Dr. Steiner has given to the insulin precursor, is less active biologically than insulin. However, it reacts with insulin antibodies in such a way that some testing methods would not show a strong difference between proinsulin and insulin.

Proinsulin's Presence in Blood

Whether proinsulin is present in the blood is not known. "However," Dr. Steiner said, "it is possible that in diabetics and others an enzyme deficiency may cause proinsulin, rather than insulin, to be released into the circulation."

Dr. Steiner's studies have been in progress for two years under a U.S. Public Health Service grant.

He has been investigating human tumor cells which produce insulin.

"Work in our laboratory," said Dr. Steiner, "indicates the two polypeptide chains of insulin are synthesized as parts of a single longer polypeptide chain. This single chain spontaneously folds into a staple arrangement which permits disulfide bonds to form easily, linking the insulin chains. A portion of this larger molecule is then removed by an enzyme or biological catalyst, leaving the two-chain, disulfide-

bridged insulin molecule. At least one other relatively small protein, α -chymotrypsin, is known to be formed by this mechanism while several larger proteins have been shown to arise by combination of separately made chains."

Insulin-Producing Tumor

The first observations which suggested there might be a precursor to insulin were made on slices of an insulin-producing tumor obtained from a human pancreas. When these slices were incubated with radioactive amino acids, radioactivity first appeared in this larger protein. The same radioactivity could be shown to appear subsequently in insulin. The larger protein, proinsulin, could be converted to a form indistinguishable from insulin by treatment with an enzyme called trypsin, which is known to fragment proteins. Proinsulin was also found to be closely related immunologically to insulin, a property which is not possessed by the separated chains of insulin.

Similar, more extensive, observations were made using islets of Langerhans isolated from normal rat pancreas. The islets are the site of hormone synthesis in the pancreas, comprising only about one per cent of the total tissue mass. Again, using radioisotopes, time-course studies were carried out. It was found that proinsulin is synthesized at a constant rate, has a half-life of approximately one hour, and is converted to insulin at a rate depending only on its concentration in the cell.

Not Secreted in Large Amounts

"As proinsulin comprises no more than five per cent of the total insulin-like protein in the islets, it is probably not a storage form," said Dr. Steiner. "It also accounts for less than 10 per cent of the total labeled insulin-like protein found in the medium of the islets incubated with radioactive amino acids, so it is unlikely that it is normally secreted in large amounts. Therefore, its primary function appears to be to facilitate the efficient and correct formation of the interchain disulfide bonds of insulin by readily assuming a conformation which promotes such folding."

This conclusion is supported by the ob-

servation that both rat and beef proinsulin will spontaneously refold after having their disulfide bonds completely broken. Neither rat nor beef insulin will do this to an appreciable degree under the same conditions. Furthermore, reduced beef proinsulin that has been allowed to refold can be converted with the enzyme trypsin to a biologically active form in insulin which crystallizes in the same manner as pure beef insulin.

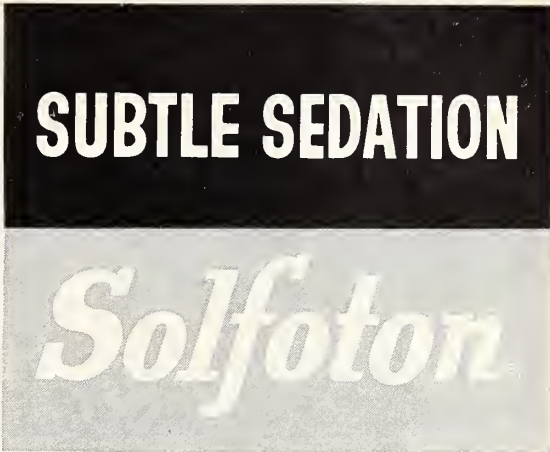
Possibilities for Future Study

According to Dr. Steiner, "establishment of a single-chain proinsulin is of great interest because of the many possibilities it offers for future study. As a single chain might be easier to make synthetically, medically useful insulin might one day be produced commercially via the proinsulin route. Also, this further understanding of the life cycle of the insulin molecule provides another area in which researchers may look for possible abnormalities in human diabetes."

When the existence of proinsulin was first demonstrated, Dr. Steiner began to examine insulin samples produced commercially to determine if they contained any proinsulin. With the cooperation of one of the world's largest producers of insulin, the Novo Company in Copenhagen, he found that commercially produced bovine insulin contains about one per cent proinsulin. Bovine proinsulin has been isolated and its amino acid sequence is being analyzed by Dr. Emanuel Margoliash, Professional Lecturer in Biochemistry, and his colleagues at the Abbott Laboratories.

Scientists working at the Eli Lilly Company in Indianapolis have recently confirmed Dr. Steiner's observations regarding proinsulin.

A revised catalog listing 77 surgical and medical science teaching films is now available from Eaton Laboratories. The 16 mm., sound, color films are listed in seven categories: urology, plastic and reconstructive surgery, burn therapy, gynecology, ophthalmology, dentistry, and cardiovascular surgery; and each title is accompanied by an abstract. For further information write: Eaton Medical Film Library, Eaton Labs, Norwich, N.Y. 13815.



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**Longevity Prospects Increased
For Married Couples**

Because of the great improvement in longevity prospects over the past 50 years, more married couples now reach the older ages together, according to statisticians of Metropolitan Life Insurance Company.

This improvement has made it necessary to reconsider what constitutes a distinctly favorable family history of longevity. For example, a husband age 25 and wife age 22 currently can look forward to reaching the wife's 60th birthday in two out of three cases. The probability is more than one out of two that the couple will survive to the wife's attaining age 65, and nearly two out of five that the couple will both live to see the wife's 70th birthday. Almost one of four couples will be alive when the wife celebrates her 75th birthday.

Fifty years ago, the corresponding chances were only about one out of two that the husband would survive to the wife's attaining age 60, and only about two out of five that he would be alive when the wife reached age 65. The chances were approximately three out of ten that both would survive to the wife's attaining age 70, and only one in six that they would together celebrate the wife's 75th birthday.

It is also significant to look at the changes in the chances of both spouses not living to the older ages. The probability that a husband age 25 and a wife age 22 would die before each has attained age 60 was only 2 percent in 1967 against 5 percent in 1917. The corresponding probabilities for both dying before reaching age 65 are estimated at 4 percent and 10 percent respectively. Prospects for not attaining age 70 are estimated at 9 and 17 percent respectively, and for not reaching age 75, the corresponding figures become 18 and 28 percent.

Statisticians suggest that male mortality is likely to remain at current levels in the years to come, but that female mortality will continue to decrease, although at a slower pace than in the past.

* * *

The National Society for the Prevention of Blindness urges individual hunters to have their eyes checked each year before taking to the woods.

SYMPOSIUM ON PERIPHERAL VASCULAR ABNORMALITIES

A significant program scheduled to be held at the Annual ISMS Convention is the Symposium on Peripheral Vascular Abnormalities, sponsored by the USV Pharmaceutical Corporation. A complimentary buffet luncheon follows the symposium.

Featured speaker will be Harold L. Karpman, M.D., FACP, FACC. Dr. Karpman is Assistant Clinical Professor of Medicine, the University of Southern California, and Chief, Peripheral Vascular Laboratory, Cedars of Lebanon Hospital, Los Angeles. He is also a Diplomate of the American Board of Internal Medicine—Cardiovascular Diseases.

The symposium will be concerned with a detailed summary of the methods which are currently available for the practical, clinical evaluation of the peripheral vascular system. The use of thermography in the areas of cardiovascular diseases, oncology, gynecology, arthralgia, and so on, will also be described.

Hospital Statistics

Expenses incurred by hospitals in providing one patient with one day of care in 1968 averaged \$65.24, according to a recent article in *Hospitals*, Journal of the American Hospital Association. This represents a 12.4% increase over the 1967 average daily expense of \$58.06.

Hospitals in 1968 employed more people and paid them higher wages than ever before, AHA said. As a result, payroll expense per patient day increased by 12.9% in 1968 over 1967—from \$36.30 to \$40.97.

The number of admissions to hospitals during 1968 increased by 2.1% to a total of 27,768,383, of which 5,711,489 were patients 65 years of age and older. A more significant increase was reported in the outpatient departments of the nation's community hospitals, where visits totaled 111,182,245 for the year, or a 6.7% increase over the 1967 total.

The frequency with which the nation's population uses hospital outpatient services reflects an increasing tendency to regard hospitals as community health centers where a wide range of health care services are available.

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ADVANCES IN MEDICINE, One Week, May 12
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ADVANCED CARDIOLOGY, One Week, June 9
CLINICAL ENDOCRINOLOGY, One Week, June 9
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(Continued from page 624)

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June 2—International Association for Accident and Traffic Medicine

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June 2—American Psychiatric Association

Committee on Psychiatry & Medical Practice
International Conference on Drug Abuse
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June 2-6—American Society of Anesthesiologists

16th Annual Anesthesiology Review Course
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Lackland Air Force Base, Texas

June 3-4—The American and European Associations of Poison Control

International Conference on Poison Control

June 3-12—International College of Surgeons

6th European Federation Congress
London, England

June 5-6—Technician's Intl. Congress on Automated Analysis

Symposium on Multiphasic, Biomedical Health Profiling and Population Screening
"Serum Profile and Clinical Diagnosis"
Chicago

June 6—American Heart Association

Abstracts' Deadline for 1969 Scientific Session

June 9—American Society of Anesthesiologists

Symposium on Basic Sciences Related to Anesthesiology
Montefiore Hospital, New York

June 20-21—American College of Anesthesiologists

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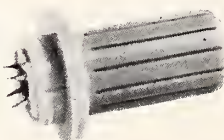
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Crisis in Child Care

(Continued from page 591)

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Freedom

What is this "True Freedom" anyway? Does it mean the right to think only of one's self and one's desires and pleasures with complete disregard of others and their rights? Not at all! This is unbridled license, quite the opposite of freedom, and it leads to complete disregard of law, order, and propriety. True freedom and liberty carry with them the obligation for restraint and acceptance of responsibility. The responsibility of parents is the proper training of and suitable punishments for children so that they will understand; it means the teaching of truth, loyalties, and thought for others and their rights and desires.

For teachers, freedom and liberty require instruction in discipline, and interest in and fairness to pupils, interest in their problems with time to discuss them and offer advice as a friend, and in teaching proper relationships and responsibilities with one another. ("Berry Pickin's;" *Resident Physician* (Sept.) 1968, p. 65).

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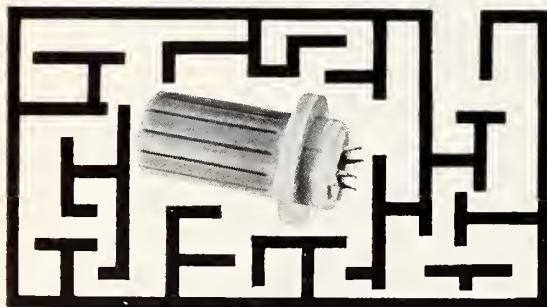
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- The Bureau of Medicine, one of the major divisions of FDA, is responsible for developing medical policy on the efficacy and safety of drugs, medical devices, and substances used in foods, drugs, cosmetics, and hazardous household products. The individual physician is assigned to one of four major subdivisions of the Bureau and reviews and evaluates scientific and clinical data relating to safety and efficacy of drugs, medical devices, and substances.
- Starting salary \$19,771 with assured periodic increases; excellent fringe benefits; professional development programs; equal opportunity; U.S. citizenship required. (The proposed pay increase would raise the starting salary to approximately \$21,600 in July 1969 if approved.)
- Located in Arlington, Virginia in modern office-apartment-shopping complex.
- Major relocation expenses reimbursed.
- We will be interviewing in Chicago May 21 and 22. To arrange an interview please call D. M. Herschler collect on 703-557-3161.
- Or write: J. J. Jennings, M. D., Acting Deputy Director, Bureau of Medicine, Code A-12, P.O. Box 2000, Eads Station, Arlington, Virginia 22202.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST

(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).



LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

473-9

THE VIEW BOX

(Continued from page 574)

Diagnosis: Intestinal knot syndrome.

This is a rare syndrome which consists of a twisting of the terminal ileum around the sigmoid colon which in turn is rotated on its own axis to create a volvulus. The prognosis is very serious unless prompt surgical intervention is carried out. The anatomical basis necessary for an intestinal knot to occur is formed by a tortuous sigmoid colon with a long freely mobile mesentery that is firmly fixed to the posterior abdominal wall and which serves as an axis for rotation. The ileum also has a long mesentery which allows free mobility and may be either in front or behind the sigmoid colon. The diagnosis can only be made radiographically. In the supine roentgenogram, the dilated closed loops assume a characteristic pattern. The sigmoid loop projects upward and to the right. The obstructed colon tapers at the point of occlusion in a fashion characteristic of simple volvulus. The obstructed and twisted ileal loops may be seen on the left side of the abdomen so that sigmoid and ileal loops are reversed in their usual position. (Fig. 1 and 2). According to Frimann-Dahl, the barium enema will show a characteristic finding on the lateral where the point of sigmoid twist is compressed by the encircling small bowel. At surgery there was a long redundant sigmoid colon which had wrapped itself around the base of a portion of the mesentery of the small bowel. Approximately 18 inches of the sigmoid and 9 feet of small bowel were gangrenous.

Reference

Frimann-Dahl, J., *Roentgen Examination in Acute Abdominal Diseases*, 2nd Edition. Charles C. Thomas, Publisher; 1960, pp. 314-321.

You, Too, Can Be a Lobbyist

The right to petition to your government is guaranteed you in the U.S. Constitution. That gives you a right to be a lobbyist, to "speak your piece" to your legislators. The truth of the matter is that our legislators want to know what we think. It helps them to arrive at decisions that properly reflect the views of the majority.—From an article in *The Log*, Pennzoil United, Inc., Houston.

BLUE SHIELD REPORT



FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 222 NORTH DEARBORN AVENUE • CHICAGO, ILLINOIS 60601

Vol. 3, No. 6

June, 1969

INDEMNITY VS USUAL AND CUSTOMARY

Basis of Payment

Indemnity plans pay the physician the amounts specified in the certificate for the services listed to apply against (but not to exceed) his fee. The amounts of indemnity are enumerated and are not intended to fix the value of the physician's services or to relate to such value. Physicians are privileged to charge their usual fees for services. The patient is responsible for any difference. Thus the protection purchased is measured; the allowances paid may not exceed the amount specified in the schedule of indemnities.

Usual and Customary payments are directly related to physicians' fees. No schedule of allowances is incorporated in the certificate. Usual charges of physicians are on record, and this individual statistical data is kept current, establishing the customary ranges by area. The program is geared to today's costs of providing health care to the public. Usual and Customary programs are designed to pay most charges in full, giving the physician realistic payment, and assuring the patient of protection in depth.

Variations

The Blue Shield Plan of Illinois Medical Service currently offers two indemnity programs for sale—the Series H and the Series I certificates. However, other indemnity certificates are actively in force. The first Blue Shield program written by Illinois Medical Service was the General Certificate (1950). Later in 1955 came the Series C and Series N certificates.

The range of Medical services covered varies with each certificate. Services covered in one contract may not be covered in another. The scope of covered services in the most widely held indemnity certificate (H-300) encompasses: Surgery, wherever performed Obstetrical Care, In-hospital Medical care, Radiology, Anesthesiology, Pathology and Emergency Accident Care. Endorsements or Riders may also be added to any basic contract to enlarge the scope of benefits.

Usual and Customary programs can have variations in the extent of payment. The major programs call for payment of 100% of Usual and Customary fees, but some are written at 80% with the patient being responsible for 20%. The popular Blue Shield 65, supplement to Medicare, is written at 20%. Other coinsurance figures are feasible and even first-dollar deductibles are not incompatible with these programs, although no such contracts are currently offered. However, in all these programs, the *basis of payment is constant*—the usual fees of the individual physician and the customary fees of similar medical practice within the area.

Special additions to the standard scope of benefits are evident in some certificates. For example, the Federal Employee Program covers consultation services; the HIA (farm groups) program covers the services of a surgical assistant.

Enrollment

Approximately 75% of Blue Shield's total membership in Illinois is enrolled under various indemnity certificates. After more than twenty years of providing this approach to prepayment of physicians' services, Blue Shield cannot immediately convert its entire enrollment to a basically different and higher-cost system. Fixed indemnity programs have worked well over the years. They are more easily understood and are the choice of many who prefer to combine the basic schedule of allowances with Major Medical Coverage for long-range protection. Blue Shield must offer plans to all segments of the population. Indemnity programs will be a significant factor for some time to come.

U & C programs in Illinois now protect almost one in four Blue Shield members. And the number continues to grow. Effective July 1st, the 80% Usual and Customary program is being offered to non-group and direct-pay subscribers. As Comprehensive Blue Cross has paid hospital bills in full for years, Usual and Customary Blue Shield now usually results in payment of charges in full for physicians. Current statistical studies show that approximately 95% of covered Medical services and 98% of the total dollar charges have been paid in full. The future looks bright for Usual and Customary and for the Blue Shield patients of Illinois physicians.

(This is not an advertisement)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Reimbursement for Physicians in a Teaching Institution

A communication has been received by all Medicare Carriers from the Social Security Administration outlining how Part B payments can be made to physicians in a teaching setting.

In the context of the directive, "physician" does *not* include any resident or intern of a hospital regardless of any other title he may hold. For example, a senior resident who is referred to as "assistant attending surgeon" would still be considered a resident and would not be eligible for Part B reimbursement.

A second qualification for eligibility for Medicare Part B reimbursement is that the teaching physician must be the patient's "attending physician." This means he "must render sufficient personal and identifiable medical services to the Medicare beneficiary" and maintain personal control over the management of that portion of the care for which there is a charge.

To qualify as the "attending physician" for a period of hospital care, the teaching physician must as a minimum:

- a. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and
- b. personally examine the patient; and
- c. confirm or revise the diagnosis and determine the course of treatment to be followed; and
- d. either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level; and
- e. be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; for the physician to be an "attending physician" his presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint; and
- f. be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization.

The fulfillment of these responsibilities must be demonstrated, in part, by "notes and orders" in the patient's records that are either written by or countersigned by the physician.

A physician in a teaching setting who fulfills the requirements as an attending physician but does so for only a segment of a patient's hospital stay is still eligible for Part B reimbursement if that portion of the stay is "a distinct segment of the patient's cause of treatment"; i.e., a pre-operative or post-operative period; also, the segment must be of significance in the continuity of the patient's care. If the teaching physician is not the "attending physician" for the duration of a segment, he can be reimbursed by Part B Medicare only for those identifiable services which he personally renders.

It was also pointed out that grand rounds made by a teaching physician, does not contribute to an "attending" relationship with a patient.

Another general exclusion applies to the supervising physician in an emergency room. He may not customarily be considered to be the "attending" physician when the patient's services are rendered by the house staff. Only through personal involvement such as personally examining the patient as well as directing and assuming the responsibility for the treatment can the supervising physician qualify as the "attending" physician.

The Medicare Carrier has the responsibility of assuring that bills submitted for payment meet the above mentioned conditions.

As an aid, the Social Security Administration has directed the carrier not to pay any bills submitted for services in the teaching setting after May 1969 unless the chief of the department or service certifies, on a form furnished by the carrier, that the services meet the requirements of an "attending" physician. As an alternative, the "attending" physician may sign the bill submitted indicating that he has met the requirements of an "attending" physician. The carrier is expected to substantiate the claims of an attending physician by checking appropriate patient records which must show that the physician provided personal and identifiable services. If a review of records indicates that a significant portion of the services do not meet the criteria, the carrier is directed to take appropriate steps to adjust the reimbursement.

Bills must indicate, when services are furnished in the teaching setting, the name of the provider and attending physician involved, and the extent of the services provided by the attending physician. The services must be defined and quantified to avoid errors in applying the reasonable charge limitation—e.g., to avoid applying the reasonable charge for a global service where only the surgical procedure or another component service was provided as an attending physician.

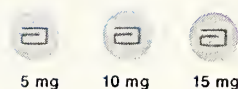
That's why Abbott's got what it takes— a pill and a program for each patient

THE PRODUCT—5 Different Strengths

For smooth appetite control plus mood elevation

Desoxyn® Gradumet®

Methamphetamine Hydrochloride in Long-Release Dose Form



For patients who can't take plain amphetamine

Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride, 60 mg. Sodium Pentobarbital

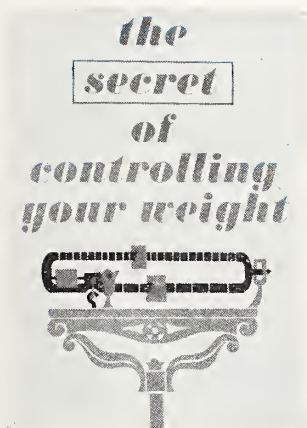


Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride, 90 mg. Sodium Pentobarbital



THE PROGRAM—3 Patient Booklets



Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. Food exchanges and a comprehensive list of foods, showing their calories, are also included.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

Compact new booklet features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

902110



Please see Brief Summary on next page.

Ask Your Abbott Man
For Patient Supplies.

BRIEF SUMMARY

Desoxyn® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates, or in those with history of manifest or latent porphyria.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Because of its sodium pentobarbital content, use Desbutal with caution in patients receiving coumarin anticoagulants. Pentobarbital may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

902110



Headache Meeting

The preliminary program for the annual meeting of the American Association for the Study of Headache, to be held July 12 in New York City, has been announced by Seymour Diamond, M.D., Chicago, secretary and program chairman.

Program highlights will include:

"Glutamate Headache," Robert Byck, M.D., and Herbert H. Schaumburg, M.D., Albert Einstein College of Medicine, Bronx, N.Y.

"Further Observations on the Role of the Nervus Intermedius in Head and Face Pain," Ernest Sachs, Jr., M.D., Hitchcock Clinic, Hanover, N.H.

"The Differential Diagnosis and Treatment of Headaches Resulting from Acute Cervical Sprain," Michael M. Gilbert, M.D., Ph.D., Miami, Fla.

"Emotional Aspects of Chronic Tension Headache," Leslie P. Weiner, M.D., The Johns Hopkins University, Baltimore, Md.

"Cluster Headache and Cluster Vertigo," Gordon J. Gilbert, M.D., St. Petersburg, Fla.

"Retinal Migraine," Desmond Carroll, M.D., London, England.

"Vasomotor Function in Migraine," Otto Appenzeller, M.D., Ph.D., associate professor of medicine, University of New Mexico, Albuquerque, N.M.

"Allergic Headache," John P. McGovern, M.D., Houston, Texas.

"Ocular Headache in Children," Philip H. Zweifach, M.D., New York, N.Y.

"Physiological Mechanisms and Treatment of Petrosal Neuralgia," Averill Stowell, M.D., Tulsa, Oklahoma.

Dr. Diamond recently authored an article in the February, 1969, issue of the *Illinois Medical Journal* entitled "Psychosomatic Aspects of Headache."

The Tall State

Illinois people developed the:

- 1st Insurance Rating Tables
- 1st Group Insurance Plan
- 1st Steel Frame Skyscraper
- 1st Stainless Steel Building
- 1st Electric Iron and Cooking Range
- 1st Pullman Car
- 1st Grain Reaper
- 1st Refrigerator Car
- 1st Controlled Nuclear Chain Reaction
- 1st Reactor to Provide Commercial Electric Power from Atomic Energy



Edward W. Cannady, M.D.

The President's Page

Last month's 129th annual meeting of the ISMS House of Delegates will always be a most memorable one for me because it was there I received the great honor of being installed as your President.

In my first "President's Page," therefore, I should like to summarize the programs and objectives proposed in my inaugural address of May 21. In future issues I will detail my plans for each of these objectives.

Although it appears our medical schools will soon be accepting more students, we must find ways to encourage graduates to practice in Illinois—especially in those areas where the physician shortage is most acute. I hope to enlist the support of all our medical schools to begin expanded internship and residency programs throughout the state.

My second major objective in the year ahead is the establishment of a sound continuing medical education program. I recommended that the Illinois State Medical Society form an independent Council on Continuing Medical Education which will help you identify your educational needs according to your interests and develop the types of instruction best suited to the requirements of various physician groups.

I'm convinced most Illinois physicians participate in some type of continuing education program. If we all become involved in such a program, there would be no justification for compulsory relicensure as proposed by the President's Commission on Health Manpower.

The proposed Council on Continuing Medical Education would be a separate body, consisting of ISMS representatives, specialty societies, the Academy of General

Practice, all Illinois and St. Louis area medical schools and other interested groups.

Because of the spiraling hospital costs we must use restraint in assessing a patient's need for hospitalization. We must resist pressure from patients and relatives to hospitalize merely because insurance programs pay benefits only for hospitalization. In this respect, we will urge the health insurance industry to increase its comprehensive coverage to include outpatient and office visits. This would help alleviate the hospital bed shortage and the high costs to patients.

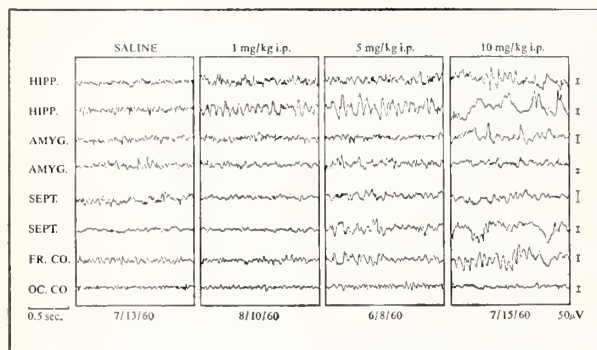
Since physicians' fees have become the subject of intense examination by government, the press, and the public, I plan to launch a comprehensive educational program to explain the "why's and wherefores" of our fees. This program will include an explanation of the so-called hidden costs that are part of the doctor's fee; and an effort to show patients how to get more value for their health dollar.

Finally, I think we should actively participate in all programs designed to strengthen the Usual and Customary fee plan developed by Blue Shield in cooperation with ISMS.

These proposals are an attempt to meet the most important issues facing Illinois physicians and the medical profession. During the coming months, I will be meeting with many of you on the President's Tour and at other meetings. I welcome your suggestions as well as your criticisms.

Edward W. Cannady

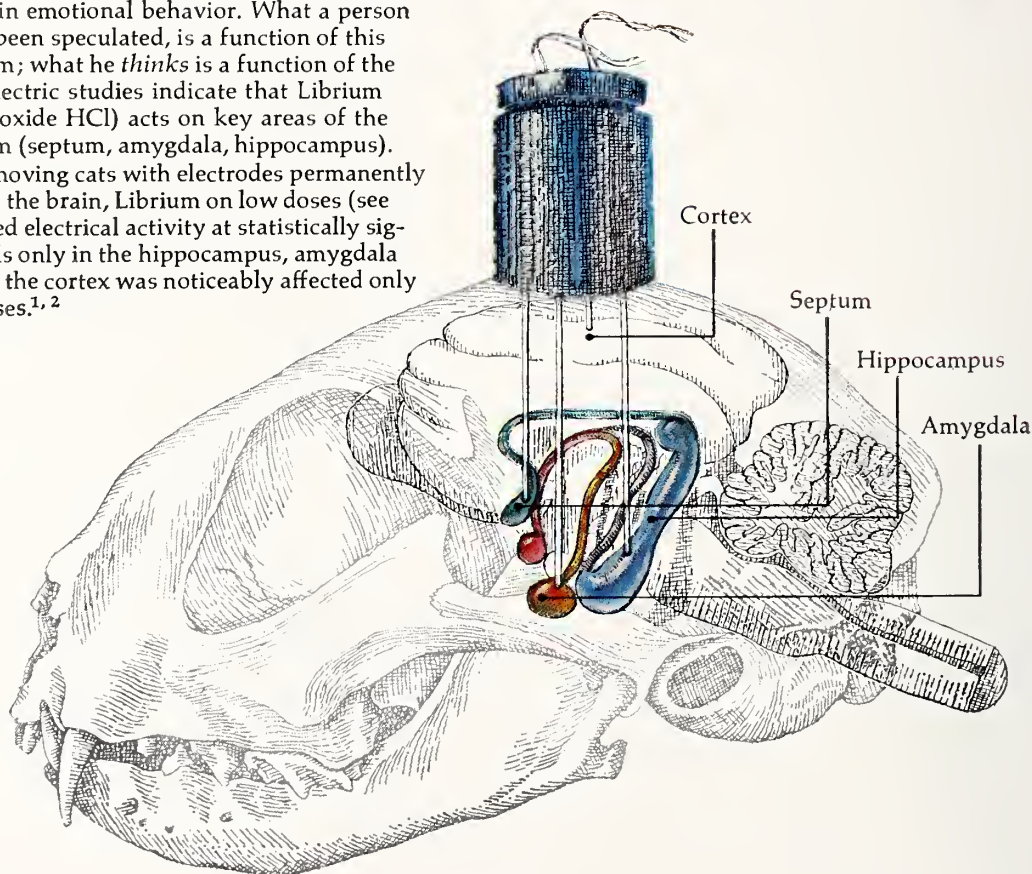
demonstrated in animal studies: selective action of Librium (chlordiazepoxide HCl) on key areas of the brain's limbic system



Spontaneous activity of EEG in unanesthetized cat with electrodes implanted in hippocampus, amygdala, septum, frontal cortex, and occipital cortex. Chlordiazepoxide HCl, 1 mg/kg i.p.: slowed the hippocampus and amygdala but induced no change in behavior. Chlordiazepoxide HCl, 5 mg/kg i.p.: slowed electrical activity in all leads including cortex; cat was sedated but awake. Chlordiazepoxide HCl, 10 mg/kg i.p.: caused slowing in all leads; cat was asleep. (Adapted from L. H. Sternbach, L. O. Randall, and S. R. Gustafson.¹)

The limbic system, also known as the visceral brain and the rhinencephalon, appears to play a fundamental role in emotional behavior. What a person *feels*, it has been speculated, is a function of this limbic system; what he *thinks* is a function of the cortex. Bioelectric studies indicate that Librium (chlordiazepoxide HCl) acts on key areas of the limbic system (septum, amygdala, hippocampus).

In freely moving cats with electrodes permanently implanted in the brain, Librium on low doses (see graph) slowed electrical activity at statistically significant levels only in the hippocampus, amygdala and septum; the cortex was noticeably affected only at higher doses.^{1, 2}



References: 1. Sternbach, L. H.; Randall, L. O., and Gustafson, S. R., in Gordon, M. J. (ed.): *Psychopharmacological Agents*, New York, Academic Press, 1964, vol. 1, pp. 161 ff. 2. Schallek, W.; Kuehn, A., and Jew, N.: *Ann. N. Y. Acad. Sci.*, 96:303, 1962.

In the complex picture
of moderate to severe anxiety...



there is a **new** reason
for prescribing **Mellaril**
(Thioridazine HCl)

**effectiveness in
mixed anxiety-depression**

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril[®]
(Thioridazine HCl)
25 mg. t.i.d.

**for moderate to severe anxiety
and mixed anxiety-depression**

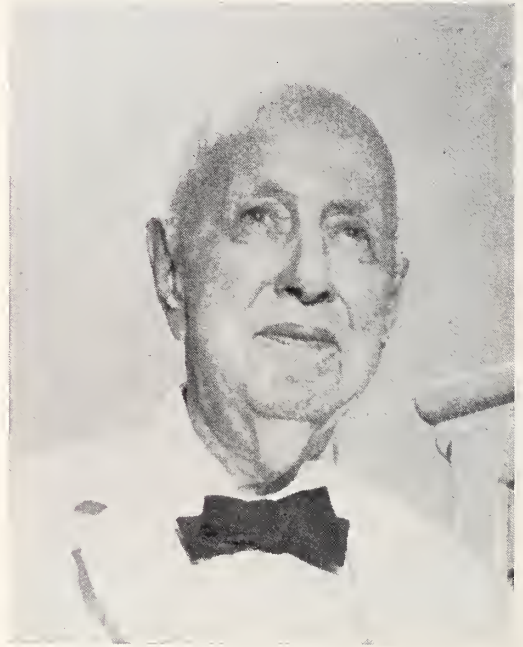


Rolland Green, Past President, Dies

The Illinois State Medical Society lost one of its most indefatigable members with the passing of Rolland Lester Green, M.D. Dr. Green, who practiced in Peoria for nearly 70 years, died April 24, at the age of 93.

Dr. Green came to Peoria in 1898 after receiving his early education in Little Rock, Ark., and graduating from the St. Louis College of Physicians and Surgeons. He was born Sept. 15, 1875, in Walnut Ridge, Ark.

In 1937 Dr. Green was elected president of the Illinois State Medical Society. He had also served as president of the Peoria Medical Society. A champion in the cause of service to handicapped children, he was named to the advisory board for the Division for Handicapped Children by Gov. Henry Horner in 1937.



While an inveterate traveler, Dr. Green made it a point to be in attendance at every annual meeting of the state medical society and only in the past few years poor health prevented his attendance. In total he attended over 50 consecutive meetings.

Dr. Green's only survivors are several distant cousins. He married Florence Pendergast, who preceded him in death in 1953. They had no children.

The state society expresses its sincere condolences to the friends and relatives of Dr. Green upon his passing.

ON THE COVER

We wish to direct our readers' attention this month to our cover which features and emphasizes the interesting and informative *Medical Progress* article by Audrey E. Evans, M.D., entitled, "Recent Advances in the Treatment of Acute Leukemia in Children," found on page 677.

New ISMS President

Edward W. Cannady, M.D.

Edward W. Cannady, M.D., an East St. Louis internist, assumed the ISMS Presidency at the Society's 129th Annual Meeting, May 18-21, in Chicago; while J. Ernest Breed, M.D., a Chicago radiologist was elected by the House of Delegates to the office of ISMS President-Elect. Dr. Breed will assume the ISMS presidency in May 1970.

Emphasizing far-reaching and crucial programs in his inaugural speech, Dr. Cannady cited three particular areas of action for the coming year:

- How physicians can help curb rising medical costs.
- How the maldistribution of physicians in Illinois can be remedied.
- How doctors can best keep up with new medical knowledge in order to provide the highest quality care to their patients.

Dr. Cannady, who was speaker of the ISMS House of Delegates from 1964-1967, succeeds Dr. Philip G. Thomsen, Dolton, as ISMS president. In addition, he is governor of the American College of Physicians for downstate Illinois, and president of the Southern Illinois Medical Association.

A physician since 1931, Dr. Cannady has been active in local, state and national medical activities related to home care, aging and cardiovascular disease. He is a past president of the Illinois Joint Council on Aging and the Illinois Heart Associa-



Edward W. Cannady, M.D.



J. Ernest Breed, M.D.

tion. Currently a member of the Illinois State Council on Aging, and the AMA Committee on Aging, he was a delegate to the 1961 White House Conference on Aging.

The new ISMS president is a member of both the Illinois and Bi-State (St. Louis Metropolitan area) Committees for Heart Disease, Cancer and Stroke Regional Medical Programs and AMA consultant to, and a board member of, the National Council on Homemaker Services, Inc.

A graduate of Washington University Medical School, St. Louis, Dr. Cannady is a member of the board of directors of Metropolitan (St. Louis) Hospital Planning Commission. He is on the staff of Barnes Hospital in St. Louis; Christian Welfare, St. Mary's and Centerville Township hospitals in East St. Louis; and Memorial and St. Elizabeth's hospitals in Belleville.

Having been active on all levels of organized medicine, Dr. Cannady was the 1952 president of the St. Clair County Medical Society, and also president of the St. Clair County Home Care Association.

ISMS' new president-elect, J. Ernest Breed, M.D., Chicago, also has established a long record of participation and leadership in medical activities and programs.

A 1928 graduate of Northwestern University Medical School, Dr. Breed has been active on a state level in medical affairs relating to ethics, religion, legislation, cancer and radiology. He has been a delegate from the Chicago Medical Society to the ISMS House of Delegates for 10 years and a member of the ISMS Board of Trustees for nine years.

He is chairman of both the Permanent Home Committee and the Legislative Information Committee of the Chicago Medical Society.

The author of many scientific papers, the new ISMS president-elect has been involved in seven motion pictures, including a recently released film on the prolongation of life.

Dr. Breed is on the staff of Augustana and Swedish Covenant hospitals and an associate in radiology at Northwestern University.

As a specialist in the treatment of cancer, Dr. Breed is a member of the Illinois Dept. of Public Health Cancer Advisory Board.

New names and faces were also added to the roster of other ISMS officials at this year's convention.

Names of Illinois physicians re-elected to their positions of leadership included: Frank J. Jirka, Jr., M.D., River Forest, Chairman, ISMS Board of Trustees; Jacob E. Reisch, M.D., Springfield, Secretary-Treasurer; and Maurice M. Hoeltgen, M.D., Chicago, Speaker of the House of Delegates.

Carl E. Clark, M.D., Sycamore, was elected ISMS First Vice-President; while George Shropshear, M.D., Chicago, was elected Second Vice-President. Paul W. Sunderland, M.D., Gibson City, was re-elected Vice Speaker of the House.

Fredric D. Lake, M.D., Chicago, was elected to replace J. Ernest Breed, M.D., ISMS president-elect, as trustee from the Third District. Renewed trusteeships included: Warren W. Young, M.D., Chicago, Third District; Mather Pfeifferberger, M.D., Alton, Sixth District; Charles K. Wells, M.D., Mt. Vernon, Ninth District; and Williard C. Scrivner, M.D., East St. Louis, Tenth District. ◀

Recent Advances In The Treatment of Acute Leukemia In Children

BY AUDREY E. EVANS, M.D./CHICAGO

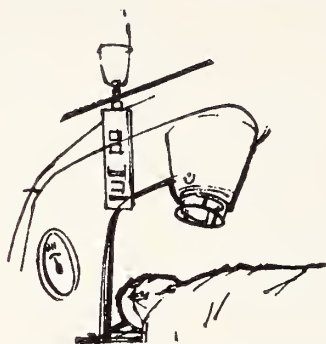
A heartening increase in the life expectancy of children with acute leukemia has followed the advances in the treatment of this disease, made in the present decade. The median survival time has increased from one to two years since the end of the 1950s, and there is an increasing number of patients surviving free of disease for over five years. Before detailing the advances that have been made, it might be helpful to review the theoretical and biochemical bases on which chemotherapeutic regimens are built.



Theory of Cellular Inhibition

Much knowledge about the various ways in which chemical agents can inhibit cellular growth and metabolism has been gained from studies in a variety of biological systems such as tissue culture, tumor transplantation, animal and bacterial models, and in man. What remains elusive is the explanation for the differential sensitivity to chemical agents that exists between malignant and most normal cells. Originally, it was thought that malignant cells multiplied faster than normal cells and had an increased metabolic rate. They thus might have been expected to respond more readily to metabolic toxins. Some alterations in this simple explanation have been made necessary by more recent studies of cell population kinetics. These suggest that some cells within a tumor have an increased resting phase and that the overall turnover time is prolonged. Whatever the reason, the hope for the future lies in isolating highly specific oncolytic agents. Perhaps more specific agents can be synthesized when the essential biochemical characteristics of malignant transformation are elucidated and understood.

Medical Progress



HARVEY KRAVITZ, M.D.
Medical Progress Editor

The complex biochemical structure of a cell is given schematically in Fig. 1 showing the sites where normal vital functions can be interrupted. The strands of DNA in the nucleus are held together as a double helix of nucleic acids, sugars and phosphate by phosphate and hydrogen bonds. These chains must replicate and act as a template for messenger RNA synthesis. Normal DNA synthesis can be altered in various ways: 1) the whole chain can be damaged physically by heat, light, high frequency waves, sound or irradiation; 2) physical agents, such as x-rays, cause cross linkage of the base pairs which in turn can lead to incorrect reduplication of the code or to dissociation from the regulator genes; 3) purine and pyrimidine analogues may be substituted into either DNA or RNA chains, interrupting the normal sequence of the molecular constituents, thus leading to false coding; 4) alternations of the sugar of the nucleotide might inhibit DNA or RNA function; 5) incorporation of purine and pyrimidine analogues gives fraudulent feedback information shutting off synthesis of the correct compound; 6) modification of the enzymes and coenzymes involved in purine or pyrimidine synthesis or of DNA or RNA polymerase could alter replication of both DNA and RNA; 7) some agents such as Actinomycin D are known to bind to DNA, thus blocking DNA dependent (messenger) RNA; 8) protein synthesis is affected by inhibition of the activator enzyme, by altering the code of ribosomal RNA or by preventing the synthesis of specific amino acids; 9) formed protein in

the cell, such as enzymes, can be inhibited in various ways.

Antimetabolites

Historically, analogues of nucleic acid and coenzymes have been classed together as antimetabolites. However, now that more is known about the method of action of all compounds in use, one could say that any one of the agents is directed against the metabolism of the cell.

AMETHOPTERIN (METHOTREXATE) This compound is one of a class that began with the closely related Aminopterin. It is of historical interest as it was the first agent found effective in the treatment of leukemia by Farber and his coworkers in 1947.⁵ A folic acid antagonist, it closely resembles folic acid and prevents the reduction of folic to tetrahydrofolic acid by the enzyme folic reductase. The reduced form of folic acid is essential for the transfer of one-carbon fragments in many biochemical reactions such as the synthesis of purine and pyrimidine bases and amino acids.

6 MERCAPTOPURINE These are several purine antagonists. The commonest in use for the treatment of leukemia is 6 Mercaptopurine (6 MP). Structurally, 6 MP is an analogue of hypoxanthine with an additional SH group. In the body, it is converted to the ribonucleotide derivative and competes for the enzymes involved in the synthesis of adenine and guanine. It also inhibits the biosynthesis of purines from small molecule precursors, possibly by means of fraudulent feedback inhibition.

CYTOSINE ARABINOSIDE This antimetabolite is a little different from the usual purine and pyrimidine analogues in that the modification is on the sugar of Cytosine. This altered compound competi-

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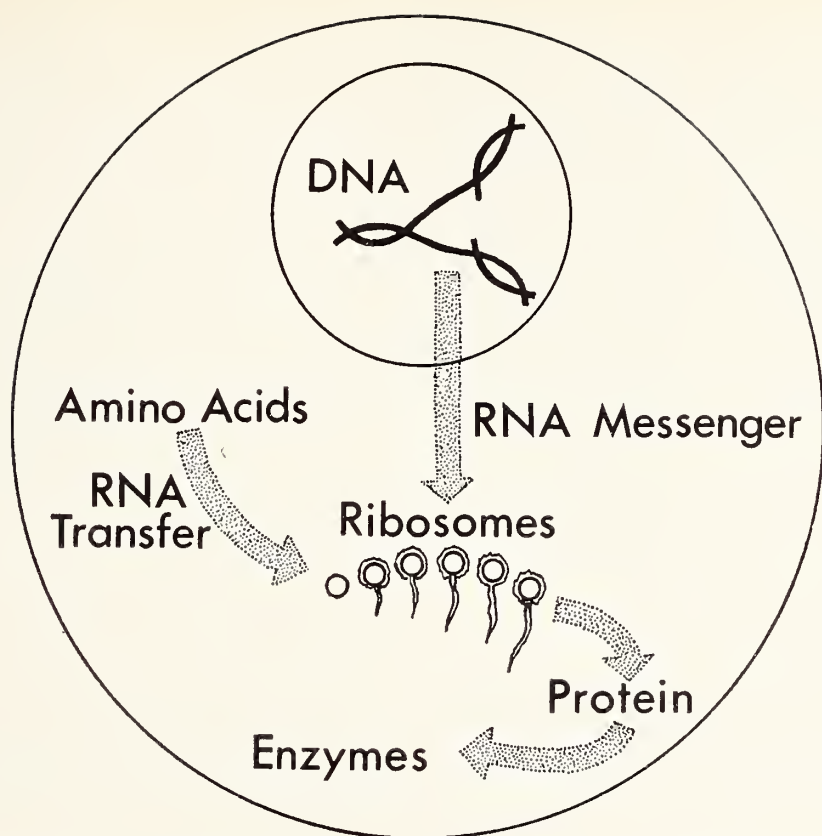


Fig. 1. *A diagram of a cell and the sites where cell metabolism might be interrupted.*

tively inhibits the conversion of cytidine ribotide to deoxyribotide, and is itself incorporated into both DNA and RNA. Its main therapeutic effect is probably by feedback inhibition.

Alkylating Agents

The alkylating agents are all modifications of the original sulphur mustard used as a chemical warfare agent in World War I. They are powerful chemical compounds which combine with phosphate, amino, sulphhydryl, hydroxyl and carboxyl groups in nucleotides and proteins. These combinations cause cross linkage in DNA and alterations in the structure of proteins. Inhibition occurs in the premitotic stage of division, causing chromosomal clumping and breakage.

CYTOXAN was the first alkylating agent found to be effective in the treatment of acute leukemia, though Chlorambucil and Myleran had been used previously for pa-

tients with chronic myeloid and chronic lymphocytic leukemia. It is an inactive cyclic compound which requires enzymatic hydrolysis to break the ring. It was hoped that an increase in the amount of this activating enzyme would be found in tumor tissue and lead to a differential sensitivity between normal and malignant cells. Unfortunately, the main normal source of this enzyme proved to be in the liver, which limits the amount of the compound that can be given.

Antibiotics

The extensive screening of microbiological filtrates, searching for new antibiotics, has included the testing of many in cancer systems for possible oncolytic action. So far, few have been found effective in the treatment of acute leukemia in humans.

DAUNOMYCIN This antibiotic, also called Rubidomycin, has a structural formula similar to the anthracyclines. It ap-

Table I
Cancer Chemotherapeutic Agents

<u>Agent</u>	<u>Therapeutic Indication</u>
ANTIMETABOLITES	
Methotrexate	Acute leukemia and Choriocarcinoma
6 Mercaptopurine	Acute leukemia
5 Fluorouracil	Carcinoma of liver and gastrointestinal tract
Cytosine Arabinoside	Acute leukemia
ALKYLATING AGENTS	
Nitrogen Mustard	Neuroblastoma and Lymphoma
Chlorambucil	Lymphoma
Myleran	Chronic myeloid leukemia
Cytosan	Acute leukemia; Neuroblastoma and Lymphoma
ANTIBIOTICS	
Actinomycin D	Wilms' tumor and X-ray potentiation
Daunomycin	Acute leukemia
Mitomycin C	Chronic myeloid leukemia and Lymphoma
Streptonigrin	Lymphoma
Mithromycin	Brain tumors
PLANT ALKALOIDS	
Vincristine	Acute leukemia; Neuroblastoma and Lymphoma
Vinblastine	Lymphoma
HORMONES	
Prednisone	Acute leukemia and Lymphoma
MISCELLANEOUS	
L-Asparaginase	Lymphocytic leukemia and Lymphoma

Specific Agents

Table I shows the classes of chemical agents found so far to be effective in cancer chemotherapy.

parently complexes with DNA, thereby inhibiting DNA dependent RNA synthesis. It also inhibits ribosomal RNA synthesis.

MITOMYCIN Mitomycin is effective in the treatment of chronic myeloid leukemia, but so far it has not been reported to cause remissions in acute leukemia. It appears to act like an alkylating agent, affecting DNA and causing chromosomal breakage.

Hormones

The biochemical effects of hormones on cellular metabolism are numerous, though which of these causes the antineoplastic effect is not known. Cortisone is particularly effective in treating abnormal lymphocytes, and there is some evidence that the hormone actually causes cell lysis by its affect on the cell wall.

Miscellaneous Agents

PLANT ALKALOIDS There are four alkaloids obtained from the periwinkle plant and they are chemically similar. They appear to inhibit mitosis in metaphase, possibly by affecting the spindle; in isolated cell systems they have no effect on respiration, nucleic acid or protein synthesis.

VINCRIStINE has shown consistent ability to produce remissions in acute leukemia and regression of lymphomas, particularly lymphosarcoma. It has many toxic side effects, particularly on the central nerv-

ous system and the G.I. tract.

VELBAN This agent has been of value in the treatment of lymphomas, particularly in Hodgkin's disease, but it has little effect on acute leukemia.

L-ASPARGINASE is an enzyme which breaks down the amino acid asparagine, and can be obtained in significant quantities from guinea pig serum and from cultures of *E. Coli*. Most mammalian cells are able to synthesize asparagine but it was found that some lymphocytes in leukemia and lymphosarcoma were dependent on external sources of asparagine, and asparaginase caused growth inhibition.

Survival Time

The median survival of children with acute leukemia was three months in the days before the antifolic compounds. In 1948, this figure rose to six months when Methotrexate was used. The addition of corticosteroids increased the survival time to seven to eight months. A plateau was reached between 1953 and 1963 when vigorous treatment with purine analogues and antibiotics led to an overall median survival of one year. In the past five years, following the use of several new drugs and variations in the schedule of treatment discussed below, children with leukemia are living much longer and some studies report a median survival time of over two years. In

addition to specific antileukemic agents, the free use of blood, blood products and antibiotics has prevented or reversed the course of many of the fatal complications which occur early in this disease.

New Agents In The Treatment of Leukemia

The following data are the result of work done by numerous investigators, many of whom work in cooperative groups. The various cooperative groups, to which reference will be made, function under the auspices of the National Cancer Institute. These teams conduct clinical trials of new agents and of new treatment methods to combat leukemia and other malignant diseases. This author is a member of Children's Cancer Study Group A (CCSGA).

Five new agents have been found to produce hematological remission in children with leukemia since 1960. They are given below in the order of their clinical trial.

CYTOXAN The first of the new useful agents identified during this period was Cytosine Arabinoside, the only alkylating agent found so far to be regularly effective in the treatment of acute leukemia. In 1962, Fernbach, et al, reported it produced remissions in children in relapse after prior therapy.⁶ As with most drugs, the response to treatment depends to some extent upon the stage of disease, when the drug is given, and whether the patient has received previous treatment. The remission rate in children previously treated is approximately 30%. The effectiveness of this agent depends in part upon the severity of relapse, unlike many other agents. Its use should probably be reserved for an occasion when relapse is detected early and the bone marrow is not completely replaced with leukemic cells. The toxic side effects are on the bone marrow, the bladder mucosa and the hair follicle. The effect on the marrow is usually not prolonged and the peripheral white count will return to normal in about one week following cessation of treatment. Hemorrhagic cystitis occurs but this complication can sometimes be prevented by insuring a high fluid intake at the time of each dose. Alopecia occurs in a proportion of patients following large doses and can be a distressing complication, but the hair will regrow if treatment is discontinued, and a wig can be worn in the interim.

VINCRISTINE, came into use shortly after Cytosine Arabinoside. It is one of a completely new class of agents. Despite its many disagreeable side effects, Vincristine (VCR) is probably the best agent for the initial treatment of leukemia because it produces the highest percentage of remissions in the shortest period of time. The remission rate of patients with acute undifferentiated or lymphocytic leukemia previously untreated is over 80%; in patients already treated with several agents, it is between 40-50%.⁴ However, remission lasts only eight weeks, and is not prolonged by continuing treatment. The use of Vincristine should perhaps be limited to induction of remission and during the course of the disease it can be used effectively for this purpose on more than one occasion. Vincristine has several undesirable side effects, mainly on the nervous system. Peripheral neuritis leading to loss of deep tendon reflexes or actual paresis, and generalized convulsions have all been encountered. Severe constipation is apparently another manifestation of neurotoxicity and can be very troublesome. Bone marrow depression, particularly affecting red cell maturation occurs even after otherwise nontoxic doses.

CYTOSINE ARABINOSIDE This purine analogue has been found to be effective in inducing remissions in children with acute lymphocytic leukemia resistant to other antimetabolites, and approximately 40% of cases with acute myeloid leukemia have also responded. At present it has to be given parenterally and the correct dose and timing is not yet established. It may prove to be a good inducing agent but a poor maintainer, similar to Vincristine. Its side effects are some degree of nausea and vomiting, and considerable depression of normal hematopoiesis, but the therapeutic ratio will probably increase when the correct dose schedule is known.

DAUNOMYCIN This antibiotic from Italy has been used with much better results in France, where it is named Rubidomycin, than it has in the United States. Bernard reports a remission rate of 54% in patients resistant to other agents.² In a small group of children with newly diagnosed leukemia, treated at Memorial Hospital in New York, together with Prednisone the remission rate was in the region of 80%.¹³ The unpleasant side effects are nausea, vomiting, myelosuppression, and

cases of myocardial toxicity have been reported.

L-ASPARGINASE This enzyme, which breaks down the amino acid asparagine, was found to inhibit the growth of lymphocytic leukemia in mice. It has been given to a small number of patients with leukemia and lymphoma. Complete remission resulted in several patients with acute lymphocytic leukemia who received adequate treatment and a dramatic response was obtained in patients with lymphosarcoma.¹⁴ Not all lymphocytes are asparagine dependent and in vitro sensitivity should be studied in each patient prior to treatment. The supply of this compound is so limited that only very preliminary studies have been possible. Efforts are now under way to purify this biological product and manufacture sufficient quantities to allow more extensive clinical trials.

Variations In Treatment Schedule **Cyclic Treatment**

Zuelzer and Brubaker both suggested that more prolonged control might be obtained if the various agents effective in the treatment of leukemia were given in rotation every two to three months, a new one being started before relapse or resistance occurred. In Zuelzer's hands, the cycling of Prednisone, Methotrexate, 6 Mercaptopurine and Cytosan produced a longer period of control than the same agents used in sequence; that is allowing relapse to occur before changing medication.¹⁶ Recently, CCSGA has completed a study of over 200 children, where one-half on a cyclic regimen was compared to the other half who received the same agents sequentially. Five agents were used, adding Vincristine to the regimen used by Zuelzer. No difference in survival was found between the two groups.⁷ It was interesting to note that the overall 50% survival time of both groups was 18 months, suggesting that a carefully planned outline of treatment for the whole course of the disease is of more benefit to the patient than haphazard alterations of drug, depending upon the clinical state of the patient or the mood of the clinician.

Intensive Treatment With Several Agents

The next attempt to improve the survival time was with the use of multiple agents

given simultaneously. Agents having different modes of action may have different toxic effects, so combined treatment with full therapeutic doses can be given without necessarily producing a serious increase in toxicity. Here the aim is to produce a "total kill" of leukemic cells. These studies originated at the National Cancer Institute. The regimens are designated by various names such as VAMP, POMP and BIKE. The initials of the first two stand for the agents used and the third one, BIKE, is derived from the fact that the agents are given "by cycle." The agents used are Vincristine, Amethopterin (Methotrexate), 6 Mercaptopurine and Prednisone.

This massive attack stems from Skipper's studies with mice. He showed that mice develop leukemia after transplantation of a single leukemic cell, and that the cells multiply at a constant rate to reach a lethal number. Each dose of an effective chemotherapeutic agent will destroy a constant proportion of cells. If enough is given to reduce the number to zero, the animal will survive.¹² It is obviously impossible to transpose animal work directly to man, but this does serve as a useful model on which to plan the treatment of leukemia. It seems logical that the best time to mount an all out attack is when the disease has just been diagnosed, and resistance to chemotherapy has not developed. Giving all effective agents simultaneously at the beginning is aimed at reducing the leukemic population to zero and curing the patient. VAMP and BIKE call for full therapeutic doses of four or five agents given together in courses for two to three months. No further treatment was given to maintain the remission. The median survival of these two groups was about 22 months. In POMP, larger than normal amounts of Prednisone, Vincristine, Methotrexate and 6 Mercaptopurine were given intermittently for three months and repeated once a month for 12 additional months; treatment was then discontinued. It is too soon to determine the median survival of this small group of patients, but as of this writing it is already longer than 22 months. All three groups apparently have more than the usual number of long term survivors who are receiving no further treatment. The exciting results of these small pilot studies require confirmation by a controlled large scale investigation. A word of caution should be

injected here—such aggressive treatment is difficult to administer, requires hospitalization, and is sometimes fatal.

High Intermittent Methotrexate

Skipper showed that better results in murine leukemia were produced when chemotherapy was given intermittently in time with the estimated cell cycle. A larger amount of the agent could be given and not be toxic to normal cells on the basis that the leukemic cells would be affected more when they had reached the same sensitive phase of development. Acute Leukemia Cooperative Group B followed this model and treated patients giving the maximum tolerated dose of Methotrexate intramuscularly every fourth day. This proved to be a more effective way of prolonging remission than the daily conventional doses of Methotrexate.¹ It has since been found that Methotrexate given orally every fourth day is more effective than daily doses for remission maintenance, but results of 6 Mercaptopurine given in this manner are no different from daily administration.

Consolidation

By this is meant the attempt to prolong the period of remission by giving one or two agents intermittently or in "pulses" during remission. For example, Leukemia Cooperative Group B has recently reported a study of patients previously treated with agents other than 6 Mercaptopurine. Subsequently, they were placed on various regimens of 6 Mercaptopurine. One group also received Vincristine and Prednisone once a month; the remission duration in this group was twice that of the patients receiving 6 Mercaptopurine alone.³ Numerous variations of this theme are currently being investigated.

"Sanctuary Therapy"

One of the difficulties preventing cure of this disease is that leukemic cells apparently survive because they are "hidden" in areas where they are not reached by adequate or lethal amounts of drug. One of these sites is the leptomeninges. A blood brain barrier exists against most antileukemic agents, excepting perhaps Cortisone, and only low nontherapeutic levels of

chemicals are found in the cerebrospinal fluid. This allows the leukemic cells to proliferate practically uninhibited by the same drug which is controlling the disease elsewhere. The meninges are said to be a sanctuary for the leukemic cell because it is protected there from the chemical agent. Inexplicably the testis, liver, kidney and spleen, all organs with good blood supplies, appear to be sanctuaries also. Mathe has shown by biopsy that all these areas can contain pathological cells when the peripheral blood, bone marrow and physical findings suggest a "complete remission."⁸ The term "sanctuary therapy" has been coined for treatment designed to deal with this problem.

The first regimen was the use of prophylactic intrathecal injections of Methotrexate before the patient ever developed signs of meningeal leukemia. This was designed to eradicate one of the sites from which leukemic cells could re-enter the circulation and initiate a relapse. Although it was found that this treatment did not prolong hematological remission, it did prevent the development of symptoms and signs of CNS leukemia. Another attempt to eradicate disease in the CNS used radiotherapy to the whole craniospinal axis, but again this did not prevent hematological relapse. Minneapolis investigators delivered radiotherapy to the brain, spinal cord, liver, spleen and kidneys of children newly diagnosed and in clinical remission. A significant prolongation of remission was not achieved, although CNS involvement did not appear before hematological relapse, a respite not enjoyed by the control, non-irradiated group.¹¹

New Concepts Of Treatment

Total Body Irradiation

For some years, radiotherapists have been interested in total body irradiation for both the treatment of the disease and to alter the body's immune mechanism preparatory to transplantation of marrow. Initially, this seemed a hopeful approach to the treatment of leukemia. Leukemic cells are very radiosensitive and low doses of irradiation suffice to kill these sensitive cells while allowing the normal hematopoietic cells to survive. Remissions of leukemia can be produced in this manner, but unfortunately they are not cures.¹⁰ Two

problems exist. Firstly when the maximum bone marrow response occurs the patient is very vulnerable to infection, usually to gram negative organisms from the alimentary tract. These infections are difficult to treat under these conditions and the outcome can be fatal. Secondly, like other forms of treatment, relapse occurs either because all the leukemic cells are not destroyed by x-ray, or the original cause is still present, precipitating another outbreak of disease. Even with an isologous bone marrow transplant to prevent the hematological consequences of irradiation, it has not so far been possible to give curative radiation doses without first reaching lethal levels, usually because of gastrointestinal tract damage.

Extracorporeal Irradiation

The use of extracorporeal irradiation of blood has been mainly in the treatment of patients with chronic lymphocytic leukemia, though Thomas has tried it for acute lymphocytic leukemia.¹⁵ With the newer concept that leukemia may be a disease of accumulation rather than proliferation, removal of circulating blasts might have a place in the treatment of acute leukemia. It is not difficult to establish an external arteriovenous fistula in a manner similar to that which is used for the artificial kidney. The blood flowing through the plastic tubing is exposed to a radioactive source. Lymphoblasts are very radio-sensitive and in this way such cells circulating in the peripheral blood are exposed to lethal irradiation. However, simply removing circulating blasts does not take care of the sites of proliferation and some combined form of treatment would probably be necessary to effect a remission.

Immunity

Another aspect of leukemia that is being pursued by some is the possibility of producing immunity to the disease. This attack seems hopeful, especially if a virus plays some part in the etiology. Even a weak immunological defense might be exploited by, for example, using it to destroy the relatively few cells remaining after an initial massive chemotherapeutic attack. Another possible role would be in aborting any tendency for recurrence of the disease. One approach to the development of immunity

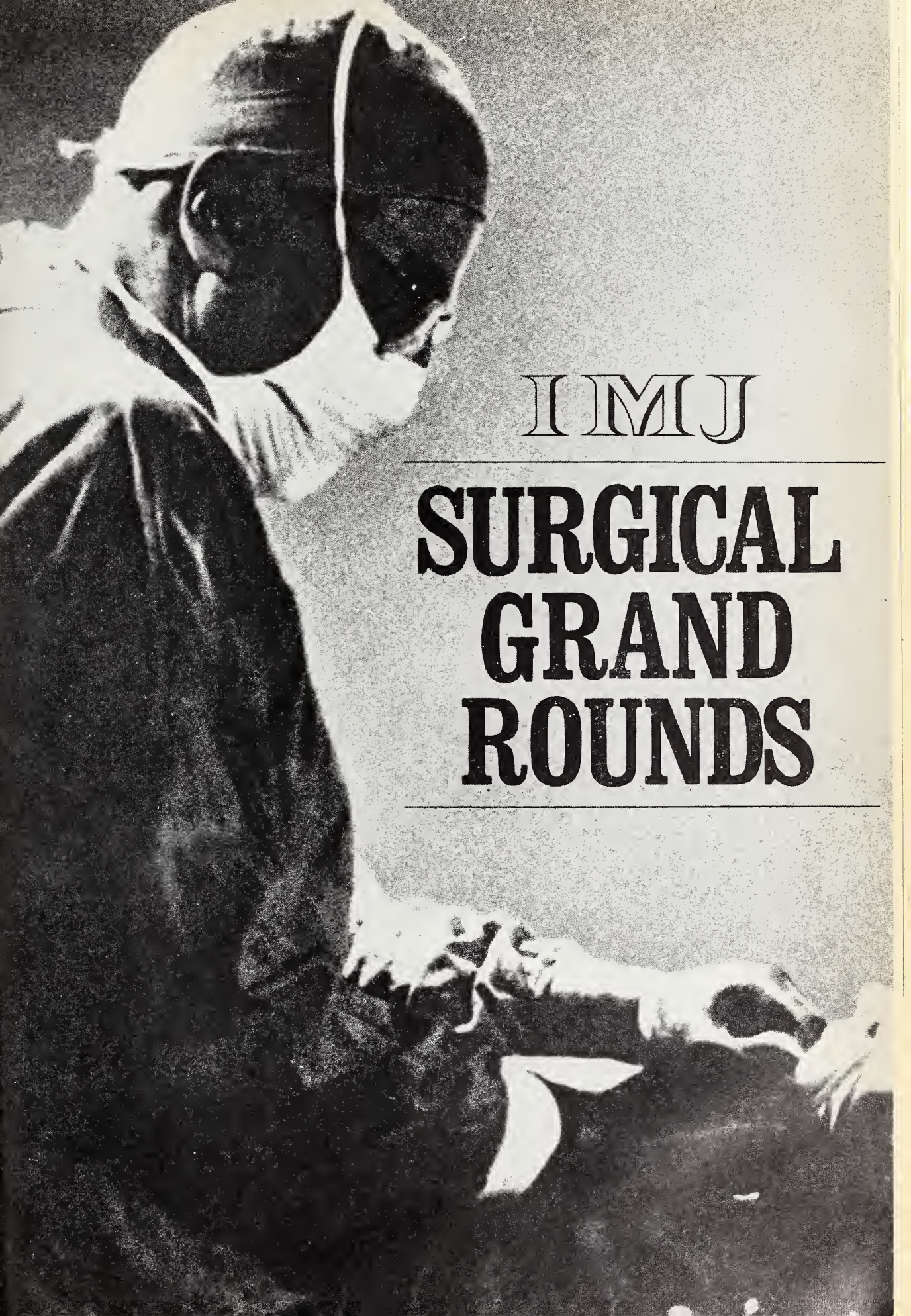
is the creation of specific antibodies to leukemic cells followed by passive transfer of the antibodies back to the patient. Sufficient quantities of leukemic cells can be obtained from the peripheral blood by plasmaphoresis of the patient or by canalizing the thoracic duct. They can be separated from red cells and plasma, and be injected into a recipient. This is not as dangerous a procedure as it sounds; so far there is no evidence that malignant disease can be transferred to a healthy human. It has been shown that the recipient makes specific antibodies to some part of the leukemic cell, and if necessary the antibody level could be maintained by subsequent boosters of antigen. Plasma from the recipient can then be used for passive immunization of the patient, or possibly the gamma-globulin fraction alone would be sufficient. An additional donor of antibodies might be the patient with a long-term remission of acute leukemia, who conceivably could have made antibodies spontaneously.

Mathe is using the combination of total body irradiation to induce a remission, together with a marrow transfusion from multiple donors, hopefully to produce a "secondary syndrome" or immunological reaction against the host cells, particularly the leukemic cells.⁵ In three patients, a remission occurred and the patients survived the secondary syndrome to have a remission lasting from 5 to over 12 months.

Comment

The treatment of acute leukemia has come a long way in the past 20 years since the advent of Aminopterin, but not far enough. The effective agents now in use are only a fraction of the number that initially looked hopeful in the test tube and the laboratory animal, but did not fulfill their promise in man. Success has attended the search for more effective ways of using these agents alone and in combination, and the result has been a considerable increase in survival time. This is a good beginning down a long and arduous road and the destination—cure of the child with leukemia—no longer seems beyond reach. ◀

(Continued on page 721)



IMJ

**SURGICAL
GRAND
ROUNDS**

Large Kidney Tumor

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on November 2, 1968.

Case Presentation

Dr. Robert Wendel: The patient, a 49 year old Negro male, was admitted to the Veterans Administration Research Hospital August 30, 1968, complaining of vague right flank pain of one month duration. However, he came to the hospital because he had not had a bowel movement in four days. In addition, he had had nausea and occasional vomiting for several days. He had lost about 10 pounds during the past

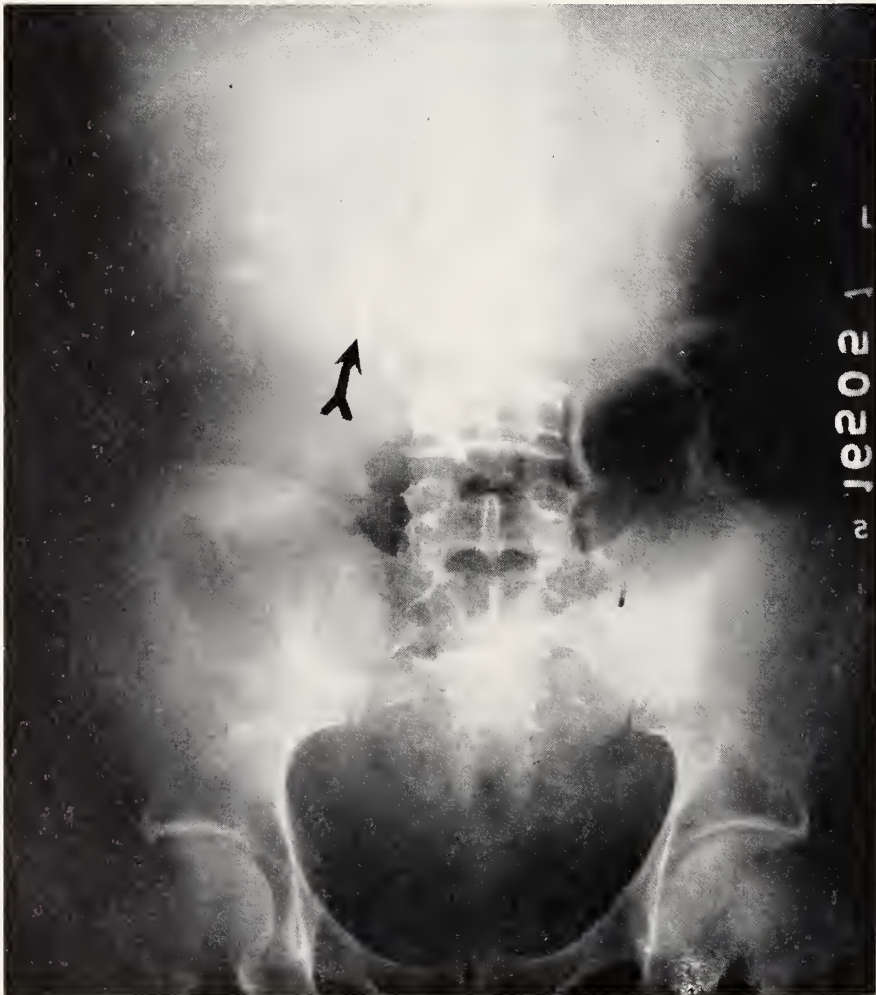


Fig. 1. Plain film of abdomen demonstrates large staghorn calculus in region of the right kidney.

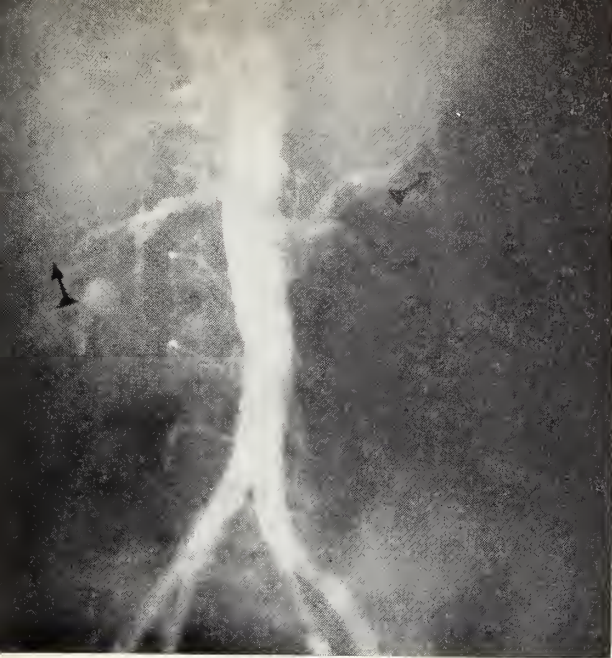


Fig. 2. Retrograde aortogram failed to demonstrate evidence of tumor.

month. He had noticed his urine had been dark and cloudy occasionally but had not had dysuria or hematuria. Pertinent physical findings were confined to the abdomen which was markedly distended. Bowel sounds were not heard. A large mass was felt in his right flank and this was tender and slightly movable. He appeared markedly toxic. His temperature was 104° , white blood cell count was 14,400 with a marked shift to the left, hematocrit 35. Urinalysis revealed numerous white cells and bacteria. After admission, x-rays of the abdomen were obtained.

Dr. Michael Murphy: A scout film on the day of admission shows a large staghorn calculus in the area of the right renal pelvis (Fig. 1). Gas in the splenic flexure of the colon is displaced toward the left side by a large right upper quadrant mass. This mass is better visualized by an intravenous pyelogram done on the following day. The right upper quadrant mass displaces the transverse colon downward. Renal function on the left is good and the collecting system is normal. Some function is present on the right. By comparing these films you can see that some contrast material is superimposed on the area of the large staghorn calculus. This represents excretion of contrast material into a cavity that is separate from the right renal pelvis but communicates with it.

Dr. Wendel: The patient did not respond to fluid administration and antibiotics over a period of 12 hours following his admission. He was taken to the x-ray department where an intravenous pyelogram was performed prior to exploration of his flank. At this time our differential diagnosis included staghorn calculus with perinephric abscess, cortical abscess, or an infected hydro-nephrotic kidney secondary to ureteropelvic obstruction. Regardless, drainage was needed at this time. The pyelogram was done with the attempt further to delineate the right kidney and, more importantly, to make sure that he had a functioning left kidney. Shortly after the x-ray studies he was taken to the operating room and a short flank incision made just below the 12th rib. Upon entering the retroperitoneal space free pus of a perinephric abscess was not encountered. A large renal mass was found which was thought to be fluctuant. This was aspirated and purulent material and old blood was obtained. Adequate incision and drainage of 500 cc. of bloody purulent necrotic material was carried out. There still remained a large mass, and therefore several other areas of the kidney were exposed and drained of similar material. Drains were left in place. In the largest cavity we left a Pezzar catheter for drainage of urine should this communicate with the renal pelvis. No staghorn calculus could be felt at any time during the procedure. Postoperatively his temperature returned to normal within 36 hours and he drained profusely into his dressing and through the tube. However, urine did not drain through the Pezzar catheter, indicating that it did not communicate with the collecting system of the kidney. Subsequently we did further diagnostic x-rays.

Dr. Murphy: A retrograde aortogram was done. This shows the drainage tubes in place in the right lower quadrant. Two left renal arteries arborize into normal appearing smaller peripheral vessels (Fig. 2). Although the right renal artery is seen, there is poor peripheral arborization of vessels on this side. No tumor vessels or areas of tumor stain are seen on this study.

Dr. Wendel: The next study was injection of the Pezzar catheter draining the cavity to see if it did communicate with the renal pelvis.

Dr. Murphy: Only a small amount reached a cavity in the area of the lower pole of the right kidney. This cavity did not appear to communicate with the renal pelvis. A retrograde pyelogram was done, and this shows medial deviation of the ureter in the area of the mass. No filling defects are seen within the ureter, and there is no evidence of tumor or stones below the level of the renal pelvis (Fig. 3).

Dr. Wendel: At the time that we had drained this mass, we felt that we were dealing with multiple cortical abscesses, probably secondary to a staghorn calculus and urinary tract infection. Cultures from the kidney grew out pure cultures of aerobacteria. Biopsy specimens of the wall of the abscess and necrotic debris failed to reveal anything other than inflammatory tissue. The patient continued to drain through the catheter. His Penrose drain was removed and the wound was healing. A renogram at this time showed minimal accumulation on the right side with a normal pattern on the left. He was found to have a creatinine clearance of 70 cc per minute, which we felt was entirely from his left kidney. Therefore it was decided to remove his non-functioning right kidney.

Exploration was done through a higher enlarged right flank incision which required removal of the 12th rib, excision of the old scar and drainage tract. The 11th rib was cut and allowed to retract upward. On exploration a large mass was found. The upper pole was perfectly smooth and approximately the size of a football, while the lower pole showed some scarring around the area previously drained. There was a separate tumor mass apparent on the medial aspect of the lower pole. The en-

Fig. 3. Retrograde pyelogram shows medial deviation of the right ureter.



tire renal mass was removed. The kidney bed and renal pedicle were free of local extension of the tumor. On section, the upper pole mass proved to be a large hematoma with almost complete destruction of parenchyma. The tumor was entirely confined to the lower pole of the kidney.

Dr. Joseph Sherrick: The gross specimen was an enormous mass weighing 1,930 grams and consisting largely of cyst containing necrotic hemorrhagic material. Yellowish-red nodules of tumor were evident around the cyst. Only one small portion of kidney could be identified, and the pelvis contained the large staghorn calculus Dr. Murphy described. The sections showed necrotic, hemorrhagic, degenerating tumor. Where the tumor was preserved, it consisted of sharply outlined cells with faintly cloudy or clear cytoplasm. In other places, the clear cells were arranged in a tubular pattern. In still other areas, there was a somewhat papillary pattern. This is a typical adenocarcinoma of the kidney, somewhat variable

in its histological appearance as they frequently are. There was no extension to the very thick capsule around this specimen, and the skin tract which was excised was not involved. Venous invasion was not detected, although one would expect to find it in a tumor as large as this one.

Dr. George Bulkley: In our experience this is an unusual situation. We were initially presented with a patient who was septic, had a bulging mass in the flank, an elevated white count, and was spiking a temperature. The surgical indications at this time were clear no matter what the etiology might prove to be since purulent material within a confined space requires drainage. So drainage was done as an emergency procedure. Our initial diagnosis was an infected calculous hydronephrotic kidney with possible perinephric abscess. These patients are very prone to continued bacteremia and bacteremic shock with its significant mortality. So we proceeded surgically to the point where we had established adequate drainage. We considered the possibility of tumor because of the type of material encountered but were never able to prove this diagnosis, either grossly or pathologically. Nephrectomy was not considered at the original operation because of the patient's general septic condition and the large size of the mass encountered. After his recovery from the incision and drainage we proceeded with diagnostic steps and found nothing which would suggest tumor, so that we were not aware of the true diagnosis until the nephrectomy was done. This tumor, I think, occurred in a kidney already infected with stone. I believe that in the development of the tumor hemorrhage occurred, and a large hematoma then became infected from the infected urine. The presenting episode was a renal abscess and the eventual outcome remains to be seen. The only other similar instance I have seen was that of a woman who presented with a perinephric abscess which was drained. She later was proven to have a clear cell renal carcinoma which eventually caused her death.

Dr. John Beal: Dr. Sherrick, was the renal vein involved by tumor?

Dr. Sherrick: It was involved in the inflammatory mass and a large section of it was removed. However, when we studied histologic sections of the renal veins, there was no tumor. In general, I think the larger an adenocarcinoma of the kidney is, the worse the prognosis is. I have seen a patient with a large cystic tumor that survived 10 years, then developed pulmonary metastases, and eventually died with metastases.

Dr. Beal: Dr. Bulkley, what role did the stone play? There was an implication that it was the reason for the infection.

Dr. Bulkley: Yes, I believe so. I think that this man had a hydronephrotic kidney with a stone in the renal pelvis and secondary urinary infection. Now I think this was coincidental to the presence of the tumor. This type of tumor is not secondary to stone as is the squamous cell carcinoma of the renal pelvis. This tumor developed in the cortex, away from the infected kidney and became secondarily infected. At the time of drainage we were not draining the renal pelvis, but a pocket created by the necrosis and breakdown of the tumor.

Dr. Beal: In attempting to excise large renal masses, some surgeons recommend a thoracic incision or transabdominal incision. Your approach proved to be very fortunate.

Dr. Bulkley: The initial approach, of course, was with the purpose of draining infected material, so we chose the most direct approach and didn't want to go through the abdomen or the chest. At the second procedure we felt that we should remain in the flank and not infect the peritoneal cavity or the pleural cavity since we were not aware of the presence of tumor. It is true that renal tumors are often approached transperitoneally and sometimes transpleurally, but I still generally use the extended flank approach which has great versatility and gives excellent exposure of the renal pedicle. ◀

"Show me a thoroughly satisfied man, and I will show you a failure."—
Thomas Edison.

EDITORIALS



Two excellent papers on the emergency care of cases of submersion were reported in *Pediatrics* in April, 1966, by Dr. Joseph Redding, Dr. Jerome Imburg and Dr. Thomas C. Hartney.^{1,2}

The following measures at the scene of a near-drowning accident should be instituted. If the victim has no spontaneous respiration, no attempt should be made to remove water from the lungs. The pharynx should be opened and mouth-to-mouth air resuscitation should be started immediately. After the first successful lung inflation the carotid pulse is checked. If no pulse is present external cardiac massage is immediately begun while artificial ventilation of the lung is continued. It is imperative that both procedures be continued during transportation to the hospital. These procedures should be done by two or more persons and should be continued until the carotid pulse is present and of good quality for a period of time even after spontaneous breathing in the victim has returned.

On arrival at the hospital, ventilation of the lungs should be continued. Vomitus should be removed from the tracheal-bronchial tree by direct laryngoscopy with tracheal intubation. Intermittent positive pressure breathing with oxygen should be started. A tracheostomy may be necessary in some cases. In cases of sea water submersion, positive pressure ventilation of the lungs should be continued with oxygen until the chest x-ray is clear and no evidence of aspiration or pulmonary edema is present.

RESUSCITATION AND TREATMENT FOLLOWING SUBMERSION

If there is no spontaneous pulse, 1 mg. of epinephrine should be injected immediately into the cardiac ventricle. If ventricular fibrillation is present, epinephrine injection and external electrical defibrillation should be instituted. An ECG should be done immediately and the patient metered on an oscilloscope.

Blood should be drawn for: hematocrit, hemoglobin (both in RBC and plasma), electrolytes, pH, CO₂ and clotting time. Begin an initial infusion of 10 cc of fluid per kilogram. In fresh-water submersion, there is a danger of hemolysis with hyperkalemia. The initial fluid should be low in potassium, plasma with a low potassium, dextran in saline, or normal saline in order of preference. In seawater submersion hyponatremia occurs, therefore the initial fluids should be low in sodium, such as salt-poor plasma, dextran in dextrose, or 5% dextrose, in order of preference.

Severe metabolic acidosis occurs during circulatory arrest. If possible, an arterial blood specimen should be checked for pH, pCO₂, pO₂. Intravenous sodium bicarbonate can correct the metabolic acidosis.

Intravenous fluid should be kept up the first few days with the total 24 hour volume low until there is no further evidence of pulmonary edema or cerebral edema or oliguria.

Hypothermia with reduction of the patient body temperature to 90°F. is recommended to combat the effect of cerebral anoxia. This will also combat the hyperpyrexia often found in these cases.

Finally, steroids and antibiotics should be started to prevent bronchopneumonia and interstitial pneumonitis.

Doctors Imburg and Hartney also stress the danger of hyperventilation in which experienced swimmers often engage prior to underwater swimming in an effort to prolong underwater time. This procedure can result in a lowered partial pressure of CO₂ and a sharp drop in the arterial oxygen saturation before the blood CO₂ can rise. The swimmer can develop sudden loss of consciousness without warning. This warning should be a part of all water safety instructions.

According to the "Statistical Bulletin" of the Metropolitan Life Insurance Company, accidental drownings account for 5,000 deaths annually in the United States.

Drownings are over five times more frequent in males than females. The ratio rises to 10 to 1 between the ages of 15-19 and 12 to 1 at ages 20-24. The high mortality in males is due to the greater spirit of adventure in the male and the larger number of males participating in water sports. Drownings among males from the ages of 5-24 is second only to the motor vehicle as a cause of accidental death.

Harvey Kravitz, M.D.

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THE KLINIKUM

The Klinikum of the Free University in West Berlin is a mammoth new medical center built with the cooperation of the Germans and the Americans. It was designed to supply maximum efficiency through centralized services and supplies along with advanced automation to cut down on unnecessary labor. An eight-mile fully automatic network of pneumatic tubes rushes capsules containing documents, plasma and/or medicine at a speed of about 26 feet per second to 123 different receiver stations. To transport X-rays, an additional pneumatic tube system with push-button control connects a central depot with 10 intermediate stations and two terminals.

For maximum loads of 33 lbs. a container conveyor system transports supplies, food, files, and mail, etc., throughout the entire hospital complex. This system also is fully automatic. A control mechanism on the container is adjusted to send it at a speed of three feet per second to anyone of the 190 different destinations. A third conveyor system designed for in- and out-patient files connects the record room with various departments.

The Klinikum represents a new concept in German medicine in that it houses, under one roof, a 750 bed hospital, outpatient clinic, medical school, and research facilities. Its staff of 2,500 includes 355 physicians, 805 nurses, 295 medical-technical assistants, laboratory technicians, physical

therapists, etc. There is an administrative staff of 320 along with 725 skilled and unskilled personnel for cleaning, laundries, workshops, and other services.

Your editor was most interested in the kitchen, X-ray facilities, and a \$10 million nuclear medical department. The food is prepared in a well-designed kitchen where it is immediately deep frozen at a temperature of 40 degrees Fahrenheit below zero. It is kept in deep-freeze storage capable of holding 64,000 individual portions of vacuum packed meat, vegetable, soup, etc. The dietitians select the menus electronically. The automatic conveyor system takes the frozen meals to large distributor kitchens in each ward where they are reheated. Each distributor kitchen serves 140 patients.

The emergency department has many operating rooms and each is equipped for major surgery. We asked why these were included and received a logical answer. The surgery department is closed on week-ends and emergency operations can be performed without calling in the regular surgical teams.

Time will tell whether this \$75.5 million complex will provide good medical care and meet the needs of the community. Perhaps the Klinikum is the first indication of a change in the practice of German medicine.

T. R. Van Dellen, M.D.

Some Medical Editors I Have Known

BY MORRIS FISHBEIN, M.D./CHICAGO

My first experiences in medical editing came when I joined Dr. Ludvig Hektoen at the McCormick Institute for Infectious Diseases in 1910. Dr. Ludvig Hektoen was at the time engaged in work on the *Journal of Infectious Diseases*, of which he was co-editor with Professor E. O. Jordan at the University of Chicago. Dr. Jordan was principally concerned with developing material for the periodical, but Dr. Hektoen took the responsibility for actively editing the publication. This involved not only consideration of articles, but the securing of articles and the elimination of unnecessary diction and material. Dr. Hektoen was an orderly man. He kept accurate lists of the material submitted to him. In process of development he had a looseleaf notebook in which he kept notes of important articles that he read, and abstracts to which he would later refer in the preparation of editorials or articles of his own. Almost immediately when I became associated with him I was drawn into this work, and

learned much of what was involved in editing a publication. Shortly thereafter he assumed the responsibility for editing the collected works of Christian Fenger, leading medical figure in the development of many Chicago hospitals and schools. Here I worked frequently at night with Dr. Hektoen, actually preparing manuscripts for the printer, which involved such details as headings, sizes of type, illustrations, and similar material. Also, after a few months, Dr. Hektoen suggested that I might write an occasional editorial on any subject that interested me. These he edited personally, and sent along to Dr. George H. Simmons, editor of the *Journal of the American Medical Association*. Dr. Hektoen was paid at space rates, and divided the income from such editorials with me.

This experience led fairly soon to a request that I assist the editors of the *Bulletin* of the Rush Medical College Alumni Association in the publication of that periodical. The editors were inexperienced in that type of work, probably even more inexperienced than I. Among them were Dr. B. M. Linnell of Chicago, a practitioner who permitted me shortly thereafter to put my name after his, even before I graduated in medicine. He was listed as editor, and I as business manager. By 1915 the publication was edited by an otolaryngologist, Dr. Elmer N. Kenyon, and all of the executive committee of the association were supposed to lend a hand. This type of medical editing becomes a part of the work of any physician who participates in organizational activities in the medical profession. At various times the editors of the *Bulletin* whom I knew included also Dr. George H. Coleman, who had long been as-

Morris Fishbein, M.D., Chicago, is probably one of the most renowned medical editors in the United States today. Dr. Fishbein is presently the editor of *Medical World News*, medical editor of *Britannica Book of the Year* and contributing editor, *Postgraduate Medicine*, as well as being Professor Emeritus, University of Chicago and Rush Professor Emeritus, University of Illinois College of Medicine. In addition, Dr. Fishbein has authored over 25 books covering all phases of medicine.



sociated with Dr. Frank Billings. In 1913 I joined the staff of the *Journal of the American Medical Association* where I became associated with Dr. George H. Simmons, then editor. In that association I came to know many other editors in Illinois.

History Book Preparation

In 1955 with the assistance of my daughter, Barbara F. Friedell, and with the aid of Miss Ella M. Salmonsens of the John Crerar Library, and Mrs. John Prohaska, we prepared for a book called "The History of Medical Practice in Illinois" an article on medical journalism in Illinois. Here may be found the history of each of the medical publications developed in this state, but I shall limit myself in these reminiscences to the editors I knew personally after I became a professional editor in 1913.

Specialty Journals

Among the first and most important of editors whom I knew well was Dr. Franklin H. Martin, who founded and was for many years editor of *Surgery, Gynecology and Obstetrics*. He was the founder of the American College of Surgeons, and with Dr. George W. Crile, of the Clinical Congress of Surgeons. Dr. Martin was a leader who developed this successful publication, made it the official periodical of the American College of Surgeons, and gave it to the college. He was succeeded as editor by Dr. Loyal Davis, who maintained the high quality of both material and production established by Dr. Martin. As a leader, Dr. Martin was able to secure the assistance and cooperation of men of distinction in surgery, not only in the United States, but indeed all over the world. He was in all meetings courteous and bore his distinction lightly. His humor was whimsical. When World War I threatened, he went at once to Washington to offer his services to President Woodrow Wilson; was made a member of the Council of National Defense, and took over the direction of medical employment in war activities. He secured the immediate and complete cooperation of the brothers Mayo, Drs. Crile, Edward Martin, George H. Simmons, Ochsner, and many others.

The International College of Surgeons

undertook the publication of a journal reporting its activities from the time of its foundation. At first this periodical was edited by Dr. Max Thorek, founder of the college, with great enthusiasm. After his death Dr. Philip Thorek and later Dr. Warner Bowers edited this publication. The periodical has not, however, been able to achieve special distinction in its field, which is at the same time the most highly competitive in specialty publications.

The IMJ

The *Illinois Medical Journal* was edited at various times during my association in this field by Dr. Charles J. Whalen of Illinois, Dr. Harold Camp, and Dr. Theodore R. VanDellen. Each of them gave to this work their special interest and devotion. When the cooperative Medical Advertising Bureau was developed as a means of securing general advertising for the state medical journals, the directors of the Illinois State Medical Society did not see fit to join the other state journals, and continued to maintain complete direction from this point of view in the hands of the officers of the State Medical Society. All three recognized the primary functions of the State Medical Journal to be a medium of expression, news, and organizational representation for the State Society without aspiring to national or international circulation. The *Illinois Medical Journal* has always maintained respect as a medium for the State Medical Society.

The vicissitudes of the *Bulletin* of the Chicago Medical Society over fifty years have been a reflection of the status of county medical society bulletins, which for the most part have suffered from inadequate support through either advertising or membership dues, but which occasionally have endeavored, none the less, to achieve the status of full-fledged medical journals. Often the secretary of the society carried the primary responsibility for the bulletin. More recently, under the editorship of Dr. H. K. Scatliff, the *Bulletin* of the Chicago Medical Society has filled just about perfectly the niche it is expected to occupy, and has never strained the budget of the medical society.

Journals of National Societies

As a center for most of the leading medi-

cal organizations of the United States, Illinois has also been publisher of the periodicals of special organizations such as the International College of Surgeons, the American Dental Society, and the American Hospital Association, as well as many other special organizations. The periodical "Modern Hospitals" was first produced by Dr. Otho A. Ball. Dr. Ball was a quiet, exceedingly competent administrator, who knew the field well, and who was able to develop a periodical that had complete acceptance by the administrators of hospitals, advertisers, and indeed all interested in the hospital field. As he grew older, I was able to suggest to him one of many former assistants, Robert Cunningham, as an assistant editor, and Robert Cunningham has continued to head the publication which has now merged with the McGraw-Hill Company. Through my association with the hospital field, and sitting at various times with the executives and boards of the American Hospital Association, I continually urged that the American Hospital Association should have its own publication. This was developed under Dr. Burton Caldwell. This publication called "Hospitals" is one of Illinois' great contributions to medical periodicals.

When the American Medical Association began to develop its journals in the medical specialties, the decision was reached by the Board of Trustees of the Association that the editor-in-chief, and chairman of each editorial board should be a Chicago physician. I became, therefore, associated with Dr. Joseph L. Miller, who edited *The Archives of Internal Medicine*, when I joined the American Medical Association. When some difficulties arose with this board in 1932, Dr. Nathan C. Gilbert became chief editor. Dr. Frank S. Churchill, edited the *American Journal of Diseases of Children*. In 1919 Dr. Churchill left Chicago, and was replaced by Dr. Henry F. Helmholz. In 1924 Dr. Helmholz went to the Mayo Clinic, and was succeeded by Dr. Clifford G. Grulee. Dr. William A. Pusey became the first editor of the *Archives of Dermatology and Syphilology*, which incorporated the *Journal of Cutaneous Diseases* which had been edited by Dr. Oliver F. Ormsby. Dr. Pusey was succeeded by Dr. Howard Fox of Philadelphia, who was in turn succeeded by Dr. Paul O'Leary of

Rochester, Minn., and Dr. Herbert Ratner of Chicago, who had long been assistant to Dr. Pusey, had continued the Abstracts Department, and who was fully familiar with the high standard of excellence established by Dr. Pusey. The *Archives of Neurology and Psychiatry* was edited by Dr. Hugh T. Patrick. After Dr. Patrick, Dr. H. Douglas Singer became the chief editor of the *Archives of Neurology and Psychiatry*, a publication which was later divided into two periodicals. Dr. Roy R. Grinker is now chief editor of the *Archives of General Psychiatry*. The *Archives of Otolaryngology* was first edited by Dr. George E. Shambaugh.

When the Association began to be urged to produce a publication in the field of surgery, that field was already richer in publications than almost any other medical specialty. Nevertheless, experimental surgery was coming strongly to the front of surgical interest. The *Archives of Surgery* was therefore designed to meet that area of surgical interest. Its first editor was Dr. Dean D. Lewis, and he was succeeded by Dr. Waltman Walters of the Mayo Clinic. The *Archives of Ophthalmology* arose from the desire of Dr. Herman Knapp, who had founded the publication, to secure the aid of the American Medical Association in publishing this leading journal of ophthalmology. He had grave doubts that the scientific values would be maintained. He had been subsidizing its publication with his own funds. From the first, the Association was able to publish this periodical with profit, and to secure a far larger circulation than it ever had previously. At the same time Dr. Harry Gradle of Northwestern University was editing the *American Journal of Ophthalmology*, which was keyed to a practical rather than an experimental level. This also had great success. The *Archives of Pathology* was from the first edited by Dr. Ludvig Hektoen of whom I have already written.

From time to time the American Medical Association was asked to publish periodicals in other fields, particularly obstetrics and gynecology, but could never get the assurance of adequate support particularly because the *American Journal of Obstetrics* was edited by Dr. George Kosmak of New York, and he had great loyalty among his colleagues. Nevertheless the

American Academy of Obstetrics and Gynecology determined to publish its own publication. Dr. Ralph Ries of Chicago, professor, Northwestern University, was chosen to develop and edit this publication. He had remarkable success. The publication achieved a circulation perhaps well beyond that of any other in its field, and has added materially to the efforts of the organization.

During the last five years Dr. Dwight Ingle, professor of physiology at the University of Chicago, has developed a publication issued by the University of Chicago Press called *Perspectives in Biology and Medicine*. This publication has developed a field peculiarly its own. It is definitely a "think" magazine. He has developed an advisory editorial board of distinction, as well as an editorial board. The periodical published quarterly is now in its eleventh volume; in 1968 it had a circulation of almost 5,000 and is recognized as a highly respected contribution to philosophical, literary, and cultural aspects of biology and medicine.

When the Institute of Medicine was founded, its leaders contemplated a periodical representing the higher echelons of medical thought and action in the Chicago and Illinois area. For many years proceedings of the Institute of Medicine have been published regularly, occasionally containing complete essays, but more often conden-

sations and abstracts of papers read before many affiliated medical groups. An occasional editorial, and the regular reprints of post-mortem examinations in hospitals have served as an inspiration to maintain such important activities.

Auxiliary Publications

Many of the auxiliary medical professions, pharmaceutical manufacturers and similar organizations in Illinois issue from time to time controlled circulation periodicals designed to transmit the news and activities of the organizations they represent. Many hospitals publish the proceedings of their clinical groups. Many branch medical societies publish bulletins and announcements.

In the United States, medical publishing has at various times been centered in Boston, Philadelphia, and New York. Later new centers developed in Baltimore, St. Louis, and Chicago. Because of the centralization of the headquarters offices of leading medical organizations in Chicago, this city should logically assume leadership in medical periodical publishing. However, the established facilities and offices of medical book publishers in the east tends to localize monograph and book publishing more particularly in eastern cities. In Illinois the Year Book publishers, and the C. S. Thomas Publishing Co. in Springfield, have been recognized as among the leaders in this field. ◀

G.P. in Clinic Practice

The clear trend away from General Practice has been evident for two decades. Fewer medical students choose General Practice, more established General Practitioners leave to specialize and more solo practitioners band together. Why? I do not have a pat answer to that question. I suspect they are driven from solo practice to partnerships and clinic arrangements by several attractions: 1. A rotation schedule to permit some genuine time-off for leisure, community and family activities; 2. delegation by sharing of the business activities of practice such as personnel work, insurance work, credit work, etc. to relieve them of these activities, and 3. a hope that they can create a more rewarding professional life through exchange of ideas, resources and experience. Often they recruit one second echelon person, usually a Surgeon, in such an arrangement to broaden their medical capability. While such groupings or partnerships solve some of the problems of General Practice, they do not solve them all or General Practice would be a more viable medical force than it is today.

A better solution would be to recognize the values, the challenges, and the rewards of first echelon medical care, make it an established specialty, and integrate it into a multiple specialty group. (General Practice within a Multi-Specialty Group. William R. Fifer, M.D., *Group Practice* 17:9, (Sept.) 1968, pg. 51.)

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

MERCER COUNTY: Keithsburg; population: 1,000. Only physician recently moved. Nearest physician and hospital at Aledo, 17 miles. Located 50 miles from the Quad Cities. Financial assistance can be arranged. Modern, fully equipped office building available, if desired. Agricultural area. Churches: Christian and Catholic. Grade school; bus service to nearby high school. Boating and fishing on Mississippi River. Nearest golf course at Aledo. For further information contact: Charles Wagoner or Lee McGaw, Keithsburg.

MERCER COUNTY: Sherrad; population: 750. Estimated population of trade area: 4,000. Only physician died several years ago. Nearest physician in Tri-Cities, 18 miles, and Aledo, 21 miles. Mercer County Hospital, 57 beds, located in Aledo. Office space available. Financial assistance can be arranged. Predominant nationalities: Swedish, German and English. Agricultural community. Churches: Lutheran and Presbyterian. Grade and high schools: 1,300 pupils. For further information contact: Mr. C. R. Johnson, President, Farmers' State Bank, Sherrad.

MONROE COUNTY: Valmeyer; population: 720. Trade area: 2,500. One physician. Nearest additional physician, 10 miles at Waterloo. Nearest hospital at Red Bud, 24 miles, and East St. Louis, 28 miles. St. Louis, 30 miles. Financial assistance available, if desired. Many of German descent. Agricultural area. Churches: United

Church of Christ, Catholic and Baptist. Grade and high schools. Country club at Waterloo, 10 miles. Nearest swimming pool, 12 miles. For further information contact: Valmeyer Woman's Club, Attention: Mrs. Albert Schenhardt, Box 165, Waterloo.

MONTGOMERY COUNTY: Fillmore; population: 472. Trade area: 1,500. Nearest physician at Ramsey, 12 miles, and others 14 miles. Nearest hospitals at Vandalia and Hillsboro, 86 and 46 beds. St. Louis, 88 miles. Office space available. Financial assistance available, if desired. Agricultural community. Churches: Baptist, Methodist and Lutheran. Grade school; bus service to high school at Nokomis, 14 miles. Nearest recreational facilities at Vandalia and Hillsboro. For further information contact: A. L. Whitten, R. E. Matthews or Earl Hopwood, Fillmore, or E. A. Kuehn, M.D., Vandalia.

MONTGOMERY COUNTY: Witt; population: 1,100. Trade area: 2,500. Community without a physician. Nearest doctor at Hillsboro and Nokomis, 12 and 5 miles. Nearest hospital at Hillsboro. Decatur and Springfield, 50 miles. Area of 35 square miles with over 10,000 population has one resident physician and one part time. New office building available with free rent for an indefinite period. Agricultural area. Several golf courses within 15 miles. For further information contact: Andrew P. Sarsany, Supt. of Schools, 220 N. Third St., Witt 62094. Phone: 594-2531 or 594-2402.

MORGAN COUNTY: Chapin; population: 550. Trade area: 1,500. Nearest physicians and hospitals at Jacksonville; population 20,387. Agricultural area. Churches: Lutheran, Methodist and Christian. Grade and high schools. Nearest recreational facilities at Jacksonville. Office space available in bank building. Residents now going to Jacksonville, Bluffs, Meredosia, Winchester or Beardstown for medical care. For further information contact: Mr. Harry K. Onken, Chapin.

Hemorrhage Into Spermatic Cord And Testicle Simulating Incarcerated Inguinal Hernia

An Unusual Complication of Anticoagulation Therapy

BY HIRSCH HANDMAKER, M.D., AND W. HARRISON MEHN, M.D./CHICAGO



Hirsch Handmaker, M.D., (right) is a senior resident in radiology, Northwestern University Medical School, Passavant Memorial Hospital and Wesley Memorial Hospital, Chicago. He received his B.S. degree from the University of Arizona and his M.D. degree from the University of Southern California.

W. Harrison Mehn, M.D., is a Chicago surgeon specializing in abdominal surgery. He is an assistant professor of surgery, Northwestern University Medical School and an attending staff member, Passavant Memorial Hospital, Chicago. Dr. Mehn received both an M.D. and M.S. degree from Northwestern University Medical School.

Complications occurring in patients on anticoagulation therapy are many and varied, as documented by numerous recent reports.¹⁻¹⁹ The most frequent acute clinical situations resulting from such treatment are related to gastrointestinal tract bleeding and cerebrovascular insults, with the former more frequent and amenable to surgical and/or medical correction. The serious nature of these problems requires little recapitulation since the initial condition of the patient which necessitated the use of anticoagulants (myocardial infarction, pulmonary embolism, etc.) necessarily classifies him as a "poor risk" should additional insult occur. This becomes even more prominent when the acute episode requires immediate surgical intervention as occasionally occurs with gastrointestinal bleeding producing intramural hematoma and subsequent obstruction. Judicious use of intravenous vitamin K₁ has significantly reduced the number of surgical interventions necessary to alleviate such obstruction.^{7,13,20-23} The case presented here draws attention to the multiplicity of conditions that hemorrhage can imitate.

Report Of A Case

A 57-year-old man entered Passavant Memorial Hospital complaining of dull left chest pain. Although there was no previous history of angina pectoris or cardiac disease, a similar episode had been experienced two days prior to admission, but this disappeared within a few hours. His admission blood pressure was 130/80 and the physical examination was unremarkable. Serum LDH and SGOT were not markedly elevated, but the electrocardiogram revealed signs of an acute anteroseptal myocardial infarction.

He was admitted to the Cardiac Intensive Care Unit (CICU) and Dicumarol was started. He did well over the next several days, his ECG evolving without complication or progression. On the sixth hospital day, he was to be transferred from the CICU, but early in the morning he began complaining of severe mid-abdominal pain and cramping. No chest pain, nausea or vomiting were experienced. The bowel movements the previous day were normal. His abdomen was distended and the tenderness later was localized to the left lower quadrant. The patient stated he had been told that he had a "hernia" on several occasions. The bowel sounds were hypoactive, and an extremely tender mass was present in the left scrotum. The left inguinal canal was also tender to palpation. The mass was not reduceable under analgesia and standard manipulation. Rectal examination was normal and no stool was present in the rectum. Prothrombin time was 67 seconds (control 12.3) or 5.7%. Surgical consultation was obtained and a diagnosis of a partially incarcerated left inguinal hernia and possible strangulation was made. The patient was given 10 mg. of vitamin K₁ intravenously and he was taken to the operating room. A prothrombin time obtained just prior to surgery, 60 minutes following the vitamin K₁ showed a return to 23 seconds, or 23.9%.

At surgery, cardiac monitoring was utilized and a light general anesthesia with Fluothane was administered. An oblique left inguinal incision was made, and as the external oblique muscle was divided. The spermatic cord structures appeared as a black hemorrhagic mass. These were delivered into the wound and extensive hemorrhage into the cord structures was identified. A small, indirect inguinal

hernia of two centimeters' length was found. When this was opened, the peritoneal surface was found to be free of blood. The cord structures were divided and the area closed. The testical was then delivered by scrotal inversion and a markedly necrotic and hemorrhagic periscrotal tissue was excised. Microscopic sections of the specimen confirmed the testicular necrosis. Closure was made and blood loss was estimated at 150 cc. There was no alteration of the ECG or vital signs during the procedure and the patient was returned to the CICU in excellent condition.

Dicumarol was restarted on the twelfth postoperative day and his postoperative course was essentially unremarkable. He did experience several episodes of transient chest pain and slight T wave variation on subsequent ECG's during the first postoperative week, but was discharged on the 54th postoperative day. The ECG at that time had returned to a more normal one with only signs of a resolving anteroseptal infarction. The patient continued to do well 28 months following surgery.

Comment

Most complications of anticoagulant therapy lend themselves to conservative treatment, consisting of only the deletion of the medication, or administration of an antagonist, such as vitamin K₁. On occasion, surgical intervention is required to relieve the abnormality and speed the return of homeostasis. Surgery may be required to differentiate an acute surgical emergency from an occult hemorrhagic complication^{11,17,21} as in the case discussed above. Medical management will usually achieve satisfactory patient recovery in the rare situation of an intramural hematoma producing bowel obstruction.^{7,13} The presentation of this case should alert the physician to another of the myriad and diverse manners in which complications of anticoagulant therapy can present.

Summary

An unusual presentation of a complication of anticoagulation therapy with hemorrhage into the spermatic cord and testicle simulating incarcerated hernia is reported. The diversity of clinical situations created by such complications is stressed, as well as their conservative management. ◀

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Mania and Depression Study Begun

A five year study of mania and depression was launched by the award of a grant from the National Institute of Mental Health to Washington University School of Medicine, St. Louis, Missouri. A better understanding of and improved treatment for the affective disorders is one of the primary missions of the NIMH. In addition to supporting many studies pertaining to these disorders, the Institute conducts an intensive intramural research program on this important mental health problem.

The general aims of this new program are to reformulate the clinical classifications and to develop laboratory measures of the affective disorders (mania and depression). These disorders will be studied in relation to a number of factors such as social effec-

tiveness, premenstrual tension, violence, and normal grief reactions. Biochemical studies will include investigation of brain, lactate, and carbohydrate metabolism and their relationship, if any, to depression and the study of the brain of persons who have committed suicide. The effectiveness of drug modified electroconvulsive therapy in the treatment of depression will also be evaluated.

Subjects will be patients, with and without affective disorders, selected from the inpatient wards of Renard Hospital, the psychiatric unit of Barnes Hospital and the University's School of Medicine. A 12-year followup of patients previously hospitalized with mania or depression will be continued. The families of patients will be interviewed.



THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Diagnostic Radiology, Cook County Hospital,
and Clinical Professor of Radiology, Chicago Medical School*

This 53-year-old patient entered with a chief complaint of a two day history of vomiting, crampy pain, obstipation and fever.

Physical findings revealed an acutely ill patient who was markedly distended with some tenderness in both lower quadrants.

What's your diagnosis?

- 1) Small bowel obstruction.
- 2) Small bowel volvulus.
- 3) Large bowel obstruction with secondary small bowel obstruction as a result of carcinoma.
- 4) Large bowel obstruction with secondary small bowel obstruction as a result of diverticulitis of the left colon.



Fig. 1.



Fig. 2.

(Answer on page 746)

Use of Combined Furazolidone and Tetracycline In Controlling Institutional Shigellosis

By LOUIS BELINSON, M.D., AND STEPHEN BELLACK/LINCOLN

Shigellosis, both symptomatic and asymptomatic, is endemic at the Lincoln State School, as it is at many residence schools for the mentally retarded. Two recent epidemics of shigellosis have been brought under control, and a routine developed for preventing such outbreaks by a regimen which may interest those concerned with infectious dysentery in institutional surroundings.

Background

The Lincoln State School has been operating since 1877 and now has a student population of approximately 4,500. In recent years vocational training, social and self-help skills, and social group experience have been emphasized. In a recent census about 2.5% of the students were under five years of age, 32% were of school age (6-23 years), 57% were adults (24-59 years), and 8.5% were older. About 73% of the population were severely or profoundly retarded. Approximately $\frac{2}{3}$ of the students were male.

Medically, and especially with regard to communicable diseases, the school staff must deal with the problems of admissions from $\frac{2}{3}$ of the state, where contacts with

infectious diseases are constant probabilities; there is an utter inability of many students to be continent, or to observe elementary hygienic practices such as hand-washing.

Fortunately the school residences consist of a number of cottages, so that isolation of a relatively small group of students can be accomplished fairly readily.

During the past 20 to 30 years, we have used various chemotherapeutic agents to control shigellosis, with the result that the disease has continued to be endemic here, flaring at times to near epidemic propor-



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School. He received his medical degree from the University of Chicago, Rush Medical School, and served an internship at Chicago Memorial Hospital. Dr. Belinson is certified in Administrative Psychiatry by the American Psychiatric Association which he serves as an Associate Examiner. Stephen Bellack (right) is Clinical Laboratory Supervisor at Lincoln State School and Chief Bacteriologist.

tions. In the past five years it was noticed that some species and strains were becoming resistant to chemotherapy; even during strict isolation of students and buildings to prevent cross-infection and reinfection, bacteriologic cures (three negative post-treatment stool cultures or rectal swabs) could be achieved in only 42% to 77% of those treated.

Approximately one year before the present study was undertaken, there was an outbreak of bloody mucoid febrile dysentery, in a single cottage. The organism responsible was identified as *Shigella dysenteriae* 2 (Schmitz's bacillus, or *Shigella ambigua*) in 14 students, by bedside rectal-swab cultures taken on all 176 residents. Of these, eight were symptomatic, while the other six were asymptomatic carriers. All 176 students (those clinically ill, carriers, and culture-negative persons) were given a combination of furazolidone* and oxytetracycline† for seven days, after which all were found to be negative for enteric bacillary pathogens, both by our own laboratory tests and by those of the U.S. Public Health Service Communicable Disease Center, which sent technicians to Lincoln because of their interest in the relatively uncommon and unusually virulent species and strain we had found.

Encouraged by these preliminary results, we have extended the use of the furazolidone-oxytetracycline medication to other cottages and other outbreaks, and to the development of a system for the prevention of shigellosis morbidity in this school.

Materials and Methods

During the past two to three years the occurrence of dysentery in a member of the student body or staff has been followed by screening of all persons in the cottage involved by means of cultures, and the isolation of the cottage from contact with other units of the school. Persons showing shigella-positive cultures have been treated with furazolidone, 100 mg q.i.d. and oxytetracycline, 250 mg q.i.d., in adults; children are treated according to body weight. After this dosage has been followed for seven days, three cultures are taken, usually at one day intervals, but sometimes over a longer period; one week apart for three weeks.

*Furoxone® Liquid, Eaton Laboratories (Division of the Norwich Pharmacal Company).

†Terramycin® Capsules and Tablets, Pfizer Laboratories (Division of Chas. Pfizer & Co., Inc.)

On the basis of an unpublished report that ampicillin was effective in shigellosis, we used it in one outbreak which involved eleven clinical cases and carriers in a single cottage. The entire population of the cottage was treated, after which rectal-swab culturing was repeated. Ampicillin treatment was ineffective. Initially there were eleven clinical cases and carriers combined; on the day after completion of ampicillin treatment, rectal-swab cultures showed that 13 additional persons, for a total of 24, were now positive for the organism. Furazolidone-oxytetracycline treatment then was instituted for a period of seven days, at the end of which all persons in the cottage were *Shigella*-negative.

Stool specimens are plated out on SS, EMB, and bismuth sulfite agar plates and cultured in selenite broth. Suspect colonies are differentiated by means of their biochemical and agglutinative behavior. Species and type identifications in our laboratory are confirmed by the Illinois Department of Public Health, to which we send pure cultures on agar slants. In a few cases rectal-swab specimens have been taken at various intervals after the beginning of treatment, in an effort to discover the shortest interval after which *Shigella* species were not present.

Sensitivity of the cultured organisms was determined to ampicillin, tetracycline, oxytetracycline, furazolidone, cephalothin, nalidixic acid, sodium colistimethate or colistin sulfate, and Kanamycin.

In addition to case-finding, with isolation, swab-culturing, and treatment of all persons in the same cottage, our surveillance system includes the isolation in the Receiving Building of all new arrivals at the school, and all students returning from home visits or extramural employment, until three consecutive daily cultures are negative for enteropathogens. All students leaving the school also undergo this surveillance procedure.

Results

Since March, 1966, the occurrence of clinical cases and the resulting screenings of students and staff have revealed the presence of 301 infections, with shigella in 299 persons (two of whom had two separate infections each). The great majority of these were infections with *Shigella flexneri* of Shigella Subgroup B: 263 cases.

Shigella dysenteriae (schmitzii, or ambigua) has been found 14 times (all in the same outbreak, in a single cottage), *Shigella dysenteriae* Subgroup A (type unspecified) 21 times, and *Shigella sonnei* (Subgroup D) 3 times.

In 187 cases (62% of the total) the individuals concerned were asymptomatic, and were discovered to harbor *Shigella* only through comprehensive screenings.

One student was found to harbor *Shigella flexneri* on one occasion and later *Shigella dysenteriae*, and another student's stool cultures grew out *Shigella flexneri* on two occasions, separated by a lengthy post-treatment interval during which his cultures were negative. We regard both of these histories as examples of reinfection.

The combination of furazolidone and oxytetracycline has reached 100% efficacy, both clinically and bacteriologically, and has been our standard therapeutic and prophylactic medication. No gastrointestinal or other intolerance or other untoward effect has been observed or reported. According to preliminary data, stool cultures became negative for enteric pathogens within two days after the start of this therapy. This statement includes the 187 asymptomatic-carrier cases, as well as the 114 clinical dysenteries.

The results of sensitivity testing in vitro do not agree perfectly with the clinical and bacteriologic results obtained in vivo. All antimicrobial agents tested showed fairly high scores in tests of bacterial susceptibility, but cure rates, in general, of only 50% to 75% when used individually, in the earlier series of cases. In one series on our Nursery in which four students received only oxytetracycline, two of the four receiving the oxytetracycline remained positive for *Shigella flexneri* 2b whereas all 142 who received the combined therapy were negative. These two were then treated with sulfisoxazole, which was also ineffective. They were finally treated with chloramphenicol and became negative. Mass treatment of this nursery was done due to bacteriological findings on rectal-swab survey showing an incidence of 15% of this population were acute cases and carriers of *Shigella flexneri* 2b.

We have observed that in our institution shigellosis occurs more frequently in students of lower intelligence; we rarely, if ever, see a case in a student of higher men-

tal classification.

As remarked by Gerstmann and LaVeck,¹ "mass therapy of an institutionalized population with proven Shigellosis in a few individuals is worthwhile, since it may control an epidemic." Our results confirm and extend their study.

The combined therapy with furazolidone and oxytetracycline is nearly 100% effective in clinical *Shigella* dysentery and in eradicating the carrier state. As a result of our observations in the past two years, however, we know that we are now encountering strains of the organisms which are resistant to oxytetracycline and ampicillin. We plan to investigate the efficacy of furazolidone alone.

As a result of our experiences, we have instituted the following control system:

1. All new students, those transferred from another institution as well as those returning from temporary extramural residence, are isolated in receiving wards, and stool specimens on three successive days are plated on SS, SMB, bismuth sulfite, and selenite media. Suspect colonies are further tested biochemically, and final identification is made by the use of agglutinating antisera. Stool specimens are examined for parasites and ova at this time.
2. Food handlers must have two negative cultures before reporting for work, and must have at least one, and if possible, two cultures yearly.
3. Dormitories housing the less intelligent students are checked every three to four months by immediate culturing of bedside rectal swabs. When carriers are found, the entire building is isolated, all resident students and working students are treated, and isolation is maintained until all culture-positive individuals have had three successive negative cultures (only one negative culture is required for previously culture-negative individuals). One month later the entire population of the building is cultured again.
4. Medication is the same for prophylaxis, acutely ill clinical cases, and carriers: in adults, furazolidone 100 mg q.i.d. and oxytetracycline 250 mg q.i.d., for seven days.

We believe that shigellosis is more prevalent in the general population (as well as

among residents of correctional and educational institutions) than is generally realized. In our opinion it is the fragility of the *Shigella* organism in mixed cultures which keeps the reported incidences as low as they are; these incidences would be substantially greater if it were possible to deliver viable specimens, *Shigella* in mixed bacteria such as feces, to the laboratories.

Suspecting that the presence of other organisms might be responsible in part for the brevity of *Shigella* survival in mixed culture, we have followed the practice of preparing a pure culture of *Shigella* for transmittal to the extramural laboratory. It is as a result of this practice, we believe, that the referral laboratory's findings now agree perfectly with those of our own laboratory, which processes specimens immediately.

The evident increase in the resistance of *Shigella* species and strains to antimicrobial agents is worth notice. Sulfisoxazole in our experience has been nearly completely in-

effective by clinical test. In vitro sensitivity testing with oxytetracycline and ampicillin recently has shown resistance in high concentration. Both clinically and bacteriologically, fortunately, susceptibility to furazolidone and tetracycline seems undiminished.

Summary

In a large state school for the mentally retarded, where shigellosis had been endemic and occasionally epidemic for over 20 years, a satisfactory system of surveillance, chemoprophylaxis and chemotherapy has been developed. To date, effectiveness of nearly 100% by both clinical and bacteriologic criteria, has resulted from combined medication with furazolidone and oxytetracycline. There have been no untoward effects. ◀

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New Government Folder Describes Plant Allergies

The leaves of poison ivy, oak, and sumac usually share the blame for causing an allergic rash and blisters which afflict millions of Americans during warm weather. Actually, the culprit is urushiol—an ingredient found in the sap of all tree plants—according to a new folder prepared by the National Institute of Allergy and Infectious Diseases (NIAID).

Urushiol is a potent substance affecting seven of every 10 persons it touches. It causes an allergic contact dermatitis of a severity which varies with individual sensitivity and amount of exposure. As with all allergies, it is not known why some people react to urushiol while others do not.

Contact with urushiol is necessary to develop an allergic reaction. Touching a plant is the usual method of exposure. But garden tools, work clothes, roving pets, or the smoke from burning plants can provide indirect contact with the substance.

Most people worry about scarring—

which rarely occurs—and overtreat the symptoms. Removing all urushiol from the skin and eliminating indirect contact are most important procedures. A drying lotion usually relieves the rash and its accompanying itch, although a particularly susceptible person with a severe reaction should, of course, seek a physician's care.

The new folder also devotes a section to pointers on how to recognize, avoid, and eliminate the plants.

The NIAID—one of the eight National Institutes of Health—is the primary research arm of the PHS concerned with allergic disorders and infectious diseases.

Single free copies of "Poison Ivy, Oak, and Sumac" Public Health Service publication No. 1723, may be obtained from the Information Office, National Institute of Allergy and Infectious Diseases, Bethesda, Md. 20014. Additional copies are available from the Superintendent of Documents, U. S. Government Printing Office, Washington, D.C. 20402, for 5 cents each. Bulk orders are \$3.50 for 100 copies.

Clinics for Crippled Children Scheduled

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 20 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social, and nursing service. There will be three special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

July 1—Quincy—St. Mary's Hospital
 July 2—Hinsdale—Hinsdale Sanitarium
 July 8—East St. Louis—Christian Welfare Hospital
 July 8—Peoria—General—Children's Hospital
 July 9—Joliet—St. Joseph's Hospital
 July 9—Champaign-Urbana — McKinley Hospital
 July 10—Springfield — General — St. John's Hospital
 July 10—Cairo—Public Health Building
 July 10—Peoria—Cerebral Palsy (A.M.)—St. Francis Community Clinic Area
 July 10—Sterling — Community General Hospital
 July 11—Chicago Heights — Cardiac — St. James Hospital
 July 16—Evergreen Park—Little Company of Mary Hospital
 July 17—Elmhurst — Cardiac — Memorial Hospital of DuPage County

July 17—Flora—Clay County Hospital
 July 17—Decatur—Decatur Memorial Hospital
 July 22—East St. Louis—Christian Welfare Hospital
 July 22—Danville—Lake View Hospital
 July 22—Peoria—General—Children's Hospital
 July 23—Centralia—St. Mary's Hospital
 July 23—Springfield—Cerebral Palsy—Diocesan Center
 July 23—Elgin—Sherman Hospital
 July 23—Rockford—St. Anthony Hospital
 July 25—Chicago Heights — Cardiac — St. James Hospital
 July 29—Alton—General—Alton Memorial Hospital
 July 30—Mt. Vernon — Good Samaritan Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

On Wooing the Customer

"Let us never find business so good that we quit wooing the customer. The more remote the average citizen feels from business management, the less he knows about its problems. And the less he understands about its products, the more wooing he needs."—Jenkin Lloyd Jones, editor and publisher, *The Tulsa Tribune*, and vice president, U. S. Chamber of Commerce.

Ragweed Hayfever and Asthma

BY SAMUEL J. TAUB, M.D./CHICAGO

Fuchs and Strauss¹ reported on the use of a water insoluble ragweed pollen complex in the treatment of patients sensitive to ragweed in 1959. This alum precipitated pyridine complex which is referred to as allpyral is made from whole pollen without prior defatting. They described their results over a three year period and found results with allpyral extracts to be superior to those obtained with aqueous extracts. They also reported a noticeable absence of ocular symptoms in the allpyral treated group. The following were given as compared to aqueous therapy:

1. Fewer injections
2. Better tolerance
3. Longer intervals between injections
4. Mild untoward reactions
5. Lack of local induration, irritation of toxic response.

Gaillard, Schellin and Mayers² also felt that allpyral extracts were superior to the point that they felt aqueous extracts would be superseded in the next few years.

Samuel J. Taub, M.D., F.A.C.P., is a graduate of the University of Illinois College of Medicine. He served his internship at Cook County Hospital and took advanced studies in allergy at Cornell University School of Medicine. His practice is in internal medicine and the treatment of allergic disease. Dr. Taub is Emeritus Professor of Medicine and former chairman of the Dept. of Medicine at the Chicago Medical School.



Materials and Methods

The authors Caplan and Haynes started the use of Ragweed Allpyral extract in 1964 on a large group of hay fever patients.³ Many patients were transferred from aqueous extracts to allpyral extract using the same dosage. There were no local or general reactions noted.

TABLE I

	Treated with Aqueous Extracts	Treated with Allpyral Extracts
Total Patients	531	491
Number with Satisfactory Results	487- (91%)	326- (66%)
Number with Unsatisfactory Results	44- (9%)	165- (34%)

While these authors found some advantages in the use of allpyral extracts, such as fewer local and systemic reactions and fewer injections required, nevertheless they state that satisfactory results were obtained in 91% of patients with aqueous extracts as compared to 66% with allpyral extracts. They conclude that failures reported after the use of allpyral extracts did not protect against high pollen counts. Our pollen counts in this area are considerably higher than those in the east coast area where most of the original work was done. There also are lower molecular weight components removed in the preparation of allpyral extracts which may account for the difference in results. Perhaps if the lower molecular components could be reincorporated into the final allpyral extracts there would

TABLE II

	Aqueous Extracts	Allpyral Extracts
Good results	360	260
Unsatisfactory results	40	140
Percent of good results	90%	65%
Percent of unsatisfactory results	10%	35%

be a better solution with some advantages, such as lack of local irritation, fewer constitutional reactions and longer intervals between injections.

Personal Experience

Throughout the Ragweed hay fever seasons of 1965 and 1966, I treated a group of 400 patients with ragweed allpyral extracts and an equal group on ragweed aqueous extracts. Table II indicates my findings.

Therapy with allpyral Pollen extracts were started in accordance with the directions as given by the Dome Chemical Company. Patients were divided into three categories of clinical sensitivity: 1. very sensitive, 2. moderately sensitive, 3. mildly sensitive.

Doses in Protein Nitrogen Units:

Injection 1	10	20	50
" 2	20	50	100
" 3	40	100	300
" 4	80	200	700
" 5	150	400	1,500
" 6	300	800	3,000
" 7	600	1,500	5,000
" 8	1,200	2,500	10,000

Clinical response has shown a larger percentage of failures (25%) from the use of allpyral extracts then with aqueous extracts. Perhaps the lack of response to allpyral extracts might be due to denaturation of the protein antigens as a result of the extreme alkalinity used in pyridine extraction.⁴

Conclusion

It seems rather evident, according to these investigators, that there is a marked decrease in antigenicity in the pyridine extracted Allpyral Ragweed by three criteria:

1. Lack of antibody response following immunization.
2. Marked decrease in histamine releasing ability.
3. The lack of precipitation with an anti-serum directed against ragweed antigen E.

The clinical failure with allpyral ragweed extract is already shown when compared to aqueous ragweed extract on a similar group of patients. It takes at least two seasons of treatments and comparisons to establish the efficacy of some extracts. ◀

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Proper medical care is imperative in the treatment of epilepsy. Correctly diagnosed and treated, epilepsy can be completely controlled in more than half the cases. For more information, write to Epilepsy Foundation of America, Washington, D.C., 20005.

Should Food Iron Be Increased

BY HILDA S. WHITE, PH.D./EVANSTON

The answer to the question posed requires information available from three areas—medicine, nutrition and food technology. The physicians and nutritionists must tell us whether or not there is a need for more dietary iron. If the answer is “yes,” the food technologists will have to tell us how this can be best provided—if it can be provided in foods.

As a preface to this discussion, I’d like to pose another question. “Has there been a change in the amount of iron consumed?”

It is my opinion that there has been a gradual decrease. It is my impression that there has been a slight downward trend in average daily iron intakes—at least of girls and women included in survey populations. Admittedly, differences in methods for obtaining food consumption data and changes in food composition tables make it difficult to make comparisons through the decades. However, average iron intakes of less than 10 mg. per day have been found in several recent studies of girls or women. Surveys conducted in the 1940’s and early 1950’s usually found average intakes slightly above 10 mg. per day.

Decreasing Trend

One would expect such a decrease if girls and women were consuming fewer calories now than even a decade ago. Certainly the American people are calorie conscious today. Anyone who has any association with adolescent girls or young college women cannot help but be aware of the

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This paper was presented at the Symposium on Nutrition and Food Technology, Feb. 12, 1969. The Symposium was co-sponsored by ISMS, and this is the second of a series of five papers.

almost fanatical concern about weight—or perhaps better—about an attractive, slim figure.

Iron intake may also be decreasing because of changes in food processing, handling and preparation. For example, the iron spiders and pots of grandmother's time are being replaced by aluminum, stainless steel and nonstick utensils. The increasing consumption of frozen foods may result in decreasing use by some of canned products of probable greater iron content. Convenience foods which can be prepared and served without coming into contact with any utensil, let alone an iron pot, are becoming increasingly popular. It is also difficult to evaluate the significance of such changes.

Iron Enrichment

In view of the fact that there may be a decrease in the amount of iron consumed (both food and non-food) the question posed in the title may be even more pertinent. Should food iron be increased? This implies an increase or expansion of iron fortification or enrichment of foods. This should be considered in keeping with the recent joint policy statement of the American Medical Association's Council on Foods and Nutrition and the Food and Nutrition Board of the National Academy of Sciences—National Research Council.¹ This statement endorses the current practice of iron enrichment of cereal products. These groups endorse the addition of a nutrient to foods when in keeping with all of the following circumstances:

1. A significant number of people have less than desirable intake.
2. The food to which the nutrient is added is likely to be consumed in quantities sufficient to make a significant contribution to the population in need.
3. The addition is not likely to create an imbalance of essential nutrients.
4. The nutrient added is stable under proper conditions of storage and use.
5. The nutrient is physiologically available from the food.
6. There is reasonable assurance against excessive intake to a level of toxicity.

Existing iron enrichment programs were initiated to fulfill a need. They may not be adequate. Certainly there have been many suggestions that there be increased

enrichment or fortification of foods. Let's consider then the six criteria for addition of nutrients to foods as they relate to the question of increasing the amount of food iron.

Criteria For Additional Nutrients

It can probably be assumed that boys and men whose diets are adequate in other nutrients are getting enough iron as well. The 4,000 calorie diets collected by the Food and Drug Administration for its Total Diet Study contained on the average about 35 mg. of iron as determined by analysis.²⁻³ High school boys in California and teen-age boys in Iowa had average iron intakes of about 14 mg. and 16.3 mg. per day, respectively.⁴⁻⁵ These boys' dietary habits do not look quite as good as they did before the release of the 1968 Recommended Dietary Allowances⁶ in which the iron allowance for this age group was increased from 15 to 18 mg. per day. However, mature males probably have little need for the additional iron which would be available were there to be increased enrichment or fortification of foods.

In contrast, there is a great deal of concern about the iron nutriture of adolescent girls and of women during their child-bearing years. This was dramatized by the increase in the Recommended Allowance for iron in 1963 and again in 1968. The Food and Nutrition Board recognized that the present allowance of 18 mg. of iron per day for all females from 9 to 55 yrs. of age is not likely to be met by use of foods now available.⁶ Diets may well be adequate in other nutrients and still be low in iron.

Average daily iron consumption of this population group is closer to 10 mg. than to 18 mg.⁷ and may, as suggested earlier, be decreasing. Therefore, if the recommended allowance is equated with "desirable intake," it is obvious that a significant proportion of the population, in this case mature females, are consuming less than desirable amounts of iron.

However, evaluation of dietary adequacy by comparison with recommended allowances has limitations. Dr. LeRoy Vorhis has expressed this idea well: "... Food consumption survey data cannot be used alone as a measure of nutritional adequacy. In determining nutritional status, the current and past nutrient intake must be taken into consideration, as well as an

evaluation of clinical signs and symptoms, growth and development, and biochemical data on tissue and excretory levels of nutrients."⁸

Reduced Iron Stores

In the case of iron there is increasing evidence that a large number of otherwise normal, healthy girls and women may have markedly reduced iron stores. Therefore, measurement of hemoglobin concentrations, long the principal biochemical parameter of iron nutriture, does not necessarily provide data for evaluation of the adequacy of iron intakes. Unfortunately measurement of iron stores is not a simple procedure. One good indication is the amount of non-heme iron in liver autopsy material.

Another more useful and yet reliable method is the determination of iron in a bone marrow sample obtained by biopsy. Obviously this procedure is not well suited for large scale survey studies.

In 1967 Scott and Pritchard¹⁰ reported that about one-third of the 114 college women examined had zero or only trace amounts of histologically detectable bone marrow iron. All of these young women had normal hemoglobin concentrations; they had never been known to be anemic, nor had they been pregnant, donated blood or had a history of excessive blood loss. Yet one-third of them had markedly reduced iron stores.

These findings, supported by those of other investigators, suggest that for a large number of females usual iron intakes can not prevent the depletion of storage iron. If this be the criterion for evaluation, then it can be concluded that a significant proportion of the population has less than desirable iron intakes.

However, we must gather more information relative to the prevalence of iron deficiency *per se* (i.e., low iron stores in the absence of anemia); to determine just how much dietary iron (furnished by usual mixed diets) would be required to maintain "adequate" storage iron; to define, preferably by some biochemical procedure permitting quantitative evaluation, "adequate storage iron." While one-third of the young college women studied by Scott and Pritchard had insignificant amounts of bone marrow iron, another one-third had amounts which could be considered "normal" and therefore, probably, adequate.

It's hard to imagine that the food habits of the "depleted group" were markedly different from those of the "normal" group.

Supplemental Iron

The affect on storage iron of supplemental iron must also be considered. For example, a number of the young women in my classes report that they have used or are using iron supplements, alone or in combination with vitamins.

In addition to the concern about iron nutriture of girls and women—and obviously this represents a significant segment of the total population—there is also considerable evidence that many infants and children are not presently getting enough iron. The Children's Bureau of the U.S. Department of Health, Education and Welfare stated: "Iron deficiency is almost certainly the most prevalent nutritional disorder among children in the United States."¹¹ In order to prevent iron-deficiency it was recommended that iron-fortified foods be introduced during the first few months of infancy. Relatively inexpensive iron-fortified foods suitable for infant feeding are now available in this country. Probably the need, as far as this population group is concerned, is not so much for greater iron enrichment as for programs designed to increase the use of presently available fortified foods. Of course, the cost of these foods may be a deterrent to their use by some.

While more information will be required to define more exactly the extent of the need, the first criterion listed in the joint statement relative to the addition of nutrients to foods appears to be fulfilled. A significant proportion of the population has less than desirable iron intakes. From this standpoint there would appear to be justification for the addition of more iron to foods. It should be remembered that existing and proposed Federal Regulations for iron enrichment of wheat flour and other cereal products would not permit the addition of iron in the amounts necessary to increase iron intakes to a desirable level.

The second criterion states that the food or foods selected for fortification are likely to make a significant contribution to the diet of the population in need. What food or foods, if enriched, would fulfill this criterion?

There are three possible approaches:¹²

1. Enrichment of a wide variety of processed foods
2. High fortification of a single food, either an existing one or some completely new food item
3. Increased and expanded enrichment of cereal products

It may be that a combination of these methods will be required to increase dietary iron of all segments of the population in need—for example, to supply more iron to people in different income groups, or to insure that both teen-age girls and their mothers get more iron.

I would not favor the first of these—the addition of iron to a lot of different processed foods. It would be much more difficult to evaluate the probable effectiveness of such a program. The addition of a fairly large amount of iron to one single food or type of food might be beneficial. For example, there are now available a few ready-to-eat breakfast cereals containing 8-10 mg. of iron per serving. I don't think this is the answer—nor do my young women students.

The third approach would appear to be feasible. Many cereal products are now enriched and the addition of more iron should not be much of a problem. Iron could be added to cereal foods not now enriched—to specialty bakery products, to more of the macaroni products, to all rice and cornmeal, to all breakfast cereals. The extent to which these foods should be enriched would depend on their usage by the target population.

Available data indicate that low-income families use more cereal products than do high-income families. However, there is not too much information about the actual consumption of specific cereal foods by adolescent girls and by adult women at different income levels. At a recent meeting of the Chicago Nutrition Association it was reported that cornmeal was used extensively by the teen-age girls included in a study by the Chicago Board of Health. This food would therefore appear to be a good vehicle for adding more iron to the diets of certain girls. However, enriched cornmeal would be of little value for Northwestern co-eds.

In order to help in determining to what extent cereal enrichment should be increased, we need to know more about cereal usage by the male population. The reason

for this will be evident as we consider the last criterion in the policy statement regarding addition of nutrients to foods.

With regard to the third criterion there appears to be little likelihood that increasing dietary iron by any one of the three enrichment or fortification procedures discussed would create an "imbalance of essential nutrients." Thus, this criterion seems to present no problem.

It is not possible to make an unqualified statement regarding the fourth criterion—"the nutrient added should be stable under proper conditions of storage and use." A variety of iron compounds is currently being used for enrichment and fortification of foods: reduced iron, powdered iron, ferric phosphate, sodium iron pyro-phosphate, ferrous sulfate, ferrous ammonium sulfate and ferric ammonium citrate. There appears to be some confusion about the exact composition of some of these forms. Dr. Peter Elwood, in England,¹³ has raised this question, particularly with respect to reduced and powdered iron. In general, however, ferric compounds are more stable than ferrous compounds. Reduced and powdered irons are also stable.

Iron, in stable forms, is available and of course is being used. The choice of form for enrichment depends upon the product, the level of enrichment desired and the method of application. The cost factor may also have to be considered in any increased or expanded fortification program.

The criterion stating that a nutrient added to foods must be physiologically available is likewise difficult to evaluate, because of differences in the absorption of the several iron compounds employed. In general, ferrous salts are better absorbed than are ferric salts. However, when iron compounds are added to foods, which may then undergo further processing or treatment, the form of iron added may not always be the same as that presented to the gut. Absorption studies using iron salts alone are not necessarily applicable to iron fortified foods.

Iron Absorption

Absorption of iron from a single food may not be the same as its absorption when that food is fed in combination with other foods as in ordinary mixed diets. Elwood, et al,¹³⁻¹⁴ reported that the addition of eggs to a breakfast menu markedly decreased

the absorption of radioiron added to bread. Layrisse and his colleagues¹⁵ studied the differences in iron absorption when various combinations of animal and vegetable foods were fed.

There is a need for more information about iron absorption from mixed diets. Elwood has conducted and is continuing community studies designed to determine if the consumption of iron-enriched foods, as components of ordinary diets, is effective in producing an improved iron status in women.

It has been demonstrated that children receiving iron fortified milk or formula products can maintain significantly higher hemoglobin concentrations than unsupplemented control groups. It would seem desirable to conduct comparable studies with the mature female population to test the effectiveness of increased iron enrichment of foods in maintaining desirable iron status. Such studies will have to be long-term.

Consumption Patterns

I stated earlier that we needed to learn more about actual consumption by girls and women of specific foods or types of foods. This is necessary to get some idea of what foods, if fortified, would increase dietary iron and also to determine to what extent they would need to be enriched.

We also have to know how much of these foods might be used by boys and men. Such information is necessary to evaluate the sixth criterion: to provide reasonable assurance against excessive intake to a level of toxicity. The American Medical Association's Committee on Iron Deficiency¹⁶ suggested that most males could probably tolerate exposure to as much as 50 mg. of iron per day without danger of iron overload.

If a significant proportion of our population demonstrates a need for more iron or has less than desirable intakes—certainly it would be agreed that something should be done. The evidence suggests that there is in fact a need. This need could possibly be met by more widespread use of iron supplements. (It is recognized that medicinal iron must be used to correct iron deficiency anemia once it develops.)

On the other hand, the addition of more iron to foods would appear to be a better solution. Everybody eats. Not everybody would use supplements.

If nutritionists are in agreement that food iron should be increased, then they must furnish information which will provide a sound basis for planning additional enrichment or fortification programs in keeping with the criteria discussed. ◀

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THE UNITED STATES POLITICAL SYSTEM,
David Cushman Coyle, Mentor, New
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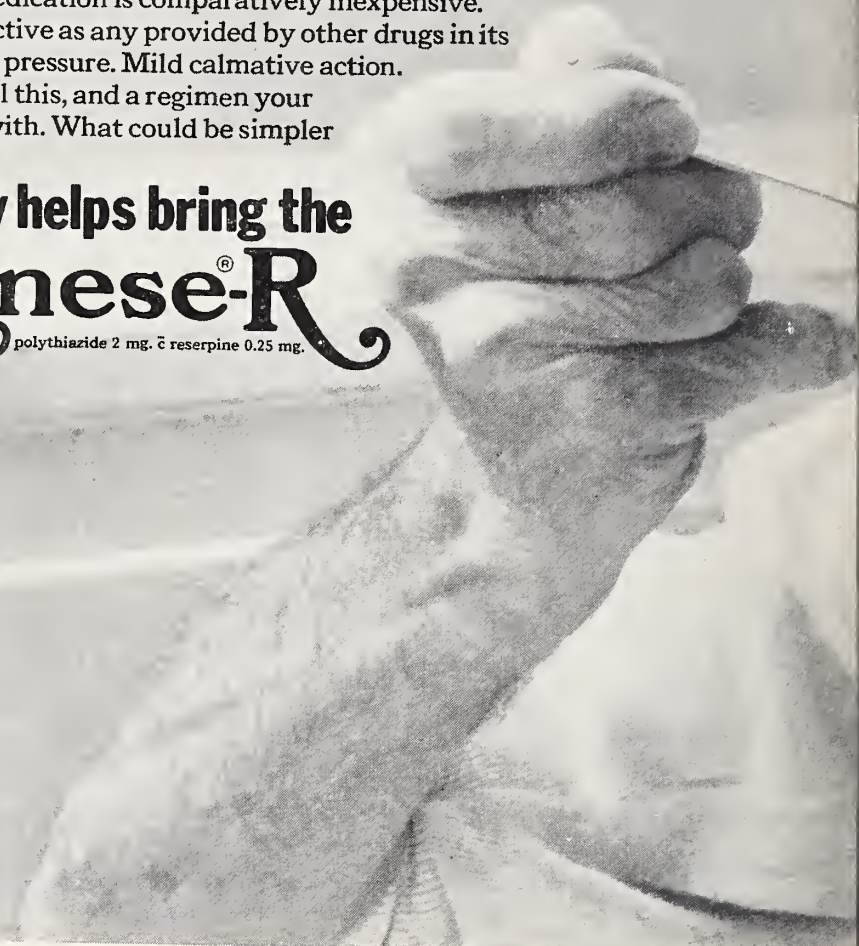
Available information tends to implicate enteric-coated potassium salts with or without thiazides in the etiology of nonspecific small

bowel lesions consisting of ulceration with or without stenosis, causing obstruction, hemorrhage and perforation, and frequently requiring surgery. Deaths due to these complications have been reported. Enteric-coated potassium salts should be used only when adequate dietary supplementation is not practical and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Renese-R does not contain enteric-coated potassium.

Electroshock therapy should not be given within one week of cessation of reserpine. **USAGE IN PREGNANCY AND THE CHILDBEARING AGE:** Since thiazides appear in breast milk, the usage of polythiazide is contraindicated in nursing mothers. Thiazides cross the placental barrier and appear in cord blood. The safety of reserpine for use during pregnancy or lactation has not been established. When polythiazide and reserpine are used in

women of childbearing age, the potential benefits of this drug combination should be weighed against the possible hazards to the fetus. The hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS: Since all diuretic agents may reduce serum levels of sodium, chloride, and potassium, patients should be observed regularly for early signs of fluid or electrolyte imbalance (fatigue, muscle cramps, gastrointestinal disturbances, lethargy, oliguria and tachycardia). Unduly restricted salt intake or digitalis therapy may exaggerate effects of hypokalemia. Should hypokalemia occur or be suspected, foods high in potassium may be added to the diet (bananas, apricots, citrus fruit juice, prune juice, etc.) or oral potassium supplements administered if necessary. Consider lower dosages of Renese-R and other antihypertensive drugs when used concur-





rently. Like other thiazide diuretics, polythiazide may cause a rise in serum uric acid levels, disturb glucose tolerance even in previously normal patients or decrease PBI levels without signs of thyroid disturbance. Thiazide drugs may augment the paralyzing actions of tubocurarine, and may decrease the arterial responsiveness to norepinephrine. The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Reserpine—Avoid or use cautiously in patients with a history of peptic ulcer or ulcerative colitis, patients with impaired renal function and in those receiving digitalis or quinidine. Extreme caution is needed in patients with a history of mental depression. If depressive symptoms, confusion or parkinsonism develop, discontinue use. Discontinue two weeks before elective surgery to avoid an unexpected degree of bradycardia and hypotension. For emergency surgery, vagal

blocking agents may be used to prevent or reverse hypotension and/or bradycardia. May cause increased appetite and weight gain.

ADVERSE REACTIONS: Polythiazide—With electrolyte imbalance: nausea, vertigo, weakness, paresthesias and fatigue. Most of these can be overcome by reducing the dose or taking measures to improve electrolyte imbalance. Maculopapular rash, reversible cholestatic jaundice, leukopenia, purpura (with or without thrombocytopenia), agranulocytosis, aplastic anemia, pancreatitis, photosensitivity, gastrointestinal disturbances, headache, xanthopsia, necrotizing angitis, orthostatic hypotension and dizziness have been reported.

Reserpine—Hypersecretion, nausea and vomiting, anorexia, diarrhea, angina-like symptoms, arrhythmias (particularly when used concurrently with digitalis or quinidine), flushing of the skin, bradycardia, drowsiness, depression, nervousness, paradoxical anxiety,

nightmares, parkinsonian syndrome, and C.N.S. sensitization manifested by deafness, glaucoma, uveitis, and optic atrophy have occurred. Nasal congestion is a frequent complaint, and pruritus, rash, dryness of mouth, dizziness, headache, purpura, impotence or decreased libido, and miosis have been reported with use of this drug. These reactions are usually reversible and disappear when the drug is discontinued.

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(Continued on page 744)

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Don't Belittle Medical Assistants Organization

Doctors who pooh-pooh medical assistants organizations are only hurting themselves, according to Dr. Philip Thomsen, immediate past president of the Illinois State Medical Society.

"Too many doctors look upon your group as just another tea-and-cookies organization that appoints committees to determine on which side of the piano the flowers should be placed," Dr. Thomsen told participants in the Illinois Medical Assistants Association's annual meeting in Oak Brook.

"Still others think you are some sort of underground union, just waiting for the right moment to throw a picket line around their office," he added.

"Obviously some of my colleagues do not know the purpose of your organization and that by helping it, they help themselves."

The objective of the group is to upgrade the professional skills of medical assistants through continuing training and certification programs. The end result is better service for the patient, as well as good public image for the doctor.

Dispelling the charge that the American Association of Medical Assistants is an attempt to unionize medical assistants, Dr. Thomsen pointed out that the organization's constitution specifically says that it "is not, nor shall ever become a trade union or collective bargaining agent."

Dr. Thomsen suggested that doctors encourage their medical assistants to join the IMAA by paying their membership dues and granting them time off to attend association workshops and meetings.

At present, only about 550 of the estimated 12,000 medical assistants in Illinois are members of the IMAA. Although some doctors have unwittingly contributed to its slow growth, Dr. Thomsen pointed out that the association must also strengthen itself from within by providing improved programming to attract new membership.

The ISMS president recommended that the group initiate practical workshops in waiting room management and efficient office bookkeeping.

"Such down-to-earth programs would serve as drawing cards for new members," he said.

Dr. Thomsen also urged the IMAA to work toward the establishment of high quality medical assistant curriculums in Illinois junior colleges. The first program of this type will begin at the Chicago YMCA college in fall, 1969.

"This is a commendable start, but it is just the beginning," he observed.

Dr. Thomsen promised the full cooperation of the ISMS staff in helping the IMAA plan and implement new programs. He also vowed to help make skeptical physicians aware of the objectives of the IMAA. ◀

Treatment of Acute Leukemia

(Continued from page 684)

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The interest rate on VA guaranteed loans may not exceed six percent per year on the unpaid balance nor may fees and charges exceed those allowed by VA.



THE BETTMANN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



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OBITUARIES

***Dr. Edward C. Albers**, Champaign, died Dec. 1, at the age of 64. He was past president of the Champaign County Medical Society.

***Dr. Naji H. Battat**, Chicago, graduate of the Ibrahim Pasha University, Cairo, Egypt, died Dec. 29, at the age of 45.

Dr. Frederick Bauer, Woodstock, died Dec. 28, at the age of 87.

Dr. Phillip M. Bedessem, Sr., Evanston, died April 30, at the age of 78.

***Dr. Everett H. Bradley**, Abingdon, died April 24, at the age of 91. He was past president of the Knox County Medical Society and a member of the ISMS Fifty-Year Club.

***Dr. Ellis A. Canterbury**, Peoria, died March 29, at the age of 56.

***Dr. Eugene F. Carey**, Richton Park, died Nov. 25, at the age of 80.

***Dr. John O. Cletcher**, Tuscola, died March 24, at the age of 81. He was past president and past secretary of the Douglas County Medical Society and a member of the ISMS Fifty-Year Club.

***Dr. Charles V. DeFuria**, Westchester, died April 16, at the age of 55. He was medical director of Northwest Hospital.

***Dr. John F. Donahoe**, Chicago, died April 14, at the age of 74.

***Dr. Abe D. Furry**, Monticello, past president and past secretary of the Piatt County Medical Society, died Dec. 14, at the age of 75. He was a member of the ISMS Fifty-Year Club.

***Dr. Willis E. Gouwens**, Flossmoor, died May 4, at the age of 74.

***Dr. Rolland L. Green**, Peoria, died April 24, at the age of 93. Dr. Green was president of the ISMS from 1937 to 1938. He also served as president of the Peoria County Medical Society. He practiced medicine for nearly 70 years and was a member of the ISMS Fifty-Year Club.

***Dr. Frank R. Hall**, Northfield, assistant

medical director of the Zenith Radio Corp., died April 6, at the age of 48.

***Dr. Frank Inks**, Princeton, died Dec. 6, at the age of 86. He was past president and past secretary of the Bureau County Medical Society and a member of the ISMS Fifty-Year Club.

***Dr. Hans Klein**, Kankakee, died April 17, at the age of 65. He was a charter member of the Kankakee Chapter of the American Academy of General Practitioners and had served as a past president of the local chapter.

***Dr. David B. Maher**, Winnetka, died April 21, in Genoa, Italy, at the age of 56. He was a member of the American Board of Ophthalmology and the American College of Surgeons.

***Dr. Allen S. Pearl, Jr.**, Oak Park, died April 9, at the age of 65. He was an associate professor in the Department of Dermatology at the University of Illinois.

***Dr. Fred Pulgram**, Trenton, died April 14, at the age of 70. He was a member of the ISMS Fifty-Year Club.

***Dr. James A. Rooney**, Oak Park, died April 26, aboard ship while bound for an Argentine vacation, at the age of 52. He was founder and chairman of the Improvement Committee of Loretto Hospital.

***Dr. William S. Sadler**, Chicago, died April 26, at the age of 93. He was a member of the ISMS Fifty-Year Club.

***Dr. Angel P. Tolentino**, Chicago, died April 10, at the age of 69.

***Dr. William G. Wallace**, Mattoon, died Feb. 4, at the age of 85. He was past president of Coles-Cumberland County Medical Society and a member of the ISMS Fifty-Year Club.

***Dr. Oliver Watry**, Evanston, Chief of Ear, Nose and Throat Surgery at Henrotin Hospital at Illinois Poly Clinic, died April 18, at the age of 73.

*Indicates Member of Illinois State Medical Society.

An Off-Year in Elections?

Thousands of cities and towns will elect municipal officials this year. Elections will be held in 850 cities with 15,000 or more population in 43 states, including New York, Detroit, Cleveland and Los Angeles.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

By JOSEPH J. LOTHARIUS

M.D.'s Must Sign IDPA Form

ISMS members are reminded by the Usual & Customary Fees Committee that individual physicians must sign the Illinois Public Aid billing forms for HIS AND ONLY HIS services. The IDPA cannot re-imburse physicians if the form is signed by a corporation or group manager.

Hospital Planning Council Raps Physicians

"Hospitals have in effect become heavily subsidized workshops for physicians." So begins a quote of Pierre de Vise, assistant director of the Hospital Planning Council of Metropolitan Chicago, from his 3-year NIH-funded project. "Each hospital bed is worth about \$4,500 a year to a physician and the general surgeon controls about 10 hospital beds, worth about \$45,000 a year in business. Looked at in economic terms, the hospital—which is a public or community institution—provides the capital equipment, while the physician provides the labor, as a private entrepreneur. In the past, the physician gave charity service in exchange for this free use of community equipment. But in the past 20 years, free physicians' services have gradually disappeared through public programs like Medicaid, while the amount of free capital equipment available per physician has greatly increased. Far from reducing their fees in exchange for this subsidized workshop and help, physicians have boosted their fees at a rate twice that of the rise in general price level."

Blame Doctors for Health Personnel Shortage

Other interesting quotes by Mr. de Vise: "Organized medicine also shares some of the responsibility for the shortage of nurses and other health personnel to the extent that it has presided over the lopsided hen-pecking order of health personnel. In no other profession or business is there such a gap in economic and social positions as in medicine. There is no one between the \$40,000 physician and the \$7,000 nurse."

(Continued on page 726)

practice management **NEWS**

A Service of the Public Relations and Economics Division

If you are about to establish a new practice or relocate in another community, one of your primary concerns may be: "How do I get started? What can I do to promote my practice in a respectable, ethical manner without incurring the criticism of my colleagues and county medical society?" To guide you, we have condensed some of the more pertinent guidelines outlined in the American Medical Association's "Judicial Council Opinions and Reports," which is an interpretation of the AMA's Principles of Medical Ethics. They are presented below:

Want To Promote Your Practice? Here's How To Do It Ethically

BY MARIAN THIELE

Announcement on Opening An Office

When you open an office, your local newspaper can carry a brief news story about the event. You may send announcements to your colleagues, personal friends outside the medical field, and anyone in fields related to medicine with whom you'll be dealing. However, avoid a mass mailing to all members of the community.

Holding "Open House"

You can invite the public to see your office if your reason for holding an open house "stems from civic and natural pride in having made a contribution to the community and to medicine . . ." But the AMA suggests that you consult your local medical society for its opinion on local custom.

Professional Cards

Limit your title to "M.D." or "Doctor of Medicine" on professional cards. If you include other honors or degrees, such as your membership in medical societies, you could be placing your M.D. title in a position of secondary importance.

Telephone Directory Listings

For the public's convenience, obviously you should be listed in your local telephone directory. But how extensive can your listing be?

The AMA's 1966 Telephone Directory Guidelines allow you to list:

(1) The abbreviation "M.D." after your name. (Both "Dr." and "Phys." include doctors of osteopathy; and "Dr." alone includes doctors of dentistry, philosophy or divinity.)

(2) Your name in an alphabetical listing with "practice limited to (specialty)," providing you are Board certified; limit your practice exclusively to specialties recognized by the AMA and the Advisory Board for Medical Specialties; and are listed under no more than two specialties or subspecialties.

(3) Answering service number

(4) Office hours or "By Appointment Only"

(5) Residence below your office listing

(6) More than one office

(7) Hospital and answering service numbers in the White Pages.

The AMA Guidelines suggest you avoid using larger or bolder type than your colleagues use, or advertising your services with a display or box advertisement.

Newspapers, Radio and TV

Should you be thrust into the public light, you may be called upon to release public news to the press and broadcasting media. The AMA Judicial Council defines **public news** as births, deaths, accidents and police cases.

Without the patient's consent, you can release information on:

Personal Data—patient's name and address, age and race; marital status; occupation and employer; parents' names (in case of birth) and next-of-kin (in case of deaths).

Nature of the Accident—extent of injuries in general terms only (the name of the body portion injured, such as "back injury") or "internal injuries;" unconscious state of the patient; type of wound (whether inflicted by knife or other sharp instrument).

Patient's General Condition—using terms such as minor injuries (or similar diagnosis) . . . good, fair, serious or critical.

You may not release information involving: suicide, intoxication or drug addiction. You may not sponsor products, make promises of radical cures, or boast of extraordinary skill or success.

Commercial Advertising Directories

Limit your listings to directories in which all physicians in the community are included equally. If you're listed in "a commercial directory that fails to include . . . the names of all licensed physicians practicing in the area served by the directory . . .", you could be accused of unethical advertising.

Reprints of Articles

You may fill requests for reprints of a medical article you have written. But don't mail them to everyone in the community or to patients who haven't requested reprints. You may be bringing "undue attention" to yourself.

Writing Health Columns

If you're actively engaged in private practice, you may only *advise* on the medical accuracy of health columns written by professional writers for the local press. But, if you're retired or practicing in the public health field, you may write health columns for publication over your name in non-medical newspapers or magazines.

Claim MD's Most Heavily Subsidized Professional in U.S.

And finally: "Physicians are the most heavily subsidized occupations in the country (sic). Their average public subsidy of close to \$10,000 per physician surpasses per capita subsidies to farmers, and greatly exceeds per capita grants to welfare, medicaid and medicare recipients. If moral decadence and public irresponsibility indeed go hand in hand with public subsidies, these elements are presumably proportional to the amount of subsidy received."

United Mine Workers Insurance Plan Still A Mystery

ISMS physicians in a multi-county area around East St. Louis remain "anxious and concerned" about the mysterious UMW expanded insurance plan. Dr. George M. Brothers, UMW area Medical Administrator, has not responded to an April 28 letter from Dr. C. S. Schlageter, Sparta, secretary of the Randolph County Medical Society. Such questions as: an explanation of benefits in the insurance plan, payment of usual and customary fees, the use of an impartial fee review committee, and why a signed agreement with the physician and beneficiary (employee) was necessary, were asked. Dr. Schlageter said area physicians were "concerned over the ethical principals involved" and are anxiously awaiting a reply.

Temporary Measures To Ease MD Shortage Studied

The ISMS Advisory Committee to the Illinois Department of Public Aid recently recommended the establishment of out-patient health clinics in medically indigent areas to help ease the acute physician shortage. The clinics would be staffed by part-time private physicians. ISMS members have already expressed interest in such a program according to a survey in which 57% of the 3,000 respondents indicated they would be willing to work "a certain number of days" in depressed areas. Tentative plans for establishing these clinics are now being considered.

YOUR ISMS INSURANCE QUESTIONS

QUESTION: *Is it advisable for a physician to carry two Professional Liability Insurance policies with different companies where both policies would provide primary coverage?*

ANSWER: No. Depending on the provisions of each insurance policy—and these vary from company to company—each company would participate in a professional liability loss. You would be well-advised to purchase a primary Professional Liability Insurance Policy and then an Excess Professional Liability policy such as provided under an "umbrella" type of insurance making certain that the professional liability exposure is also covered. In this way, you can much more economically provide very substantial limits of protection.

Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Ill. 60601. The column is a service of the ISMS Committee on Medical Economics and Insurance.

Rx To Check Child Molesting

BY SALI SIERRA/CHICAGO

Summer not only is the sound of children at play, but also a time for renewed vigilance against those sick minds who prey upon the innocence and curiosity of the young to gratify their own perverted desires. "While the child molester is an ever-present threat in all communities, the danger is seriously increased with the longer daylight hours and greater freedom children enjoy during the warm weather months," Illinois Governor Richard B. Ogilvie warns. Stressing that "indifference is the greatest ally of the child molester," he urges all parents to teach children of educable age such simple rules of self-protection as:

- Be on the alert for suspicious strangers and avoid them.
- Be sure to avoid deserted places, such as alleys and vacant lots.
- Let your parents know your whereabouts.
- A policeman is your friend and a help when you need him.
- Never accept candy or favors from a stranger, and never enter a stranger's car—no matter *what* is offered.

The Woman's Auxiliary to the Illinois State Medical Society plans to include this program in its activities during the next year.

Sali Sierra is Director of Public Relations, Society for Visual Education, Inc., Chicago. Her writings on child molestation have appeared in numerous publications, and she has discussed the problem on several radio and television programs. She attended the Art Institute of Chicago and Northwestern University, and is a member of the Division of Audio-visual Instruction of the National Education Association.

Awareness of the problem, and the exercise of sensible parental supervision, can do much to check the molester who seeks his victims in the neighborhood streets, public playgrounds, beaches, parks, forest preserves and other places frequented by youngsters at play.

Preventive Medicine

The rules cited are from the nationwide Patch the Pony educational program to teach kindergarten and elementary grade youngsters the dangers of being lured or enticed by strangers. The program, which features a legendary little brown and white cartoon pony with the slogan "Nay . . . Nay . . . From Strangers Stay Away!" was commended for outstanding achievement in the Governor's recent proclamation of "Patch the Pony Week" in Illinois. "It is my fervent hope that through a pony—the most desirable symbol for the young—the growing incidence of child molestation will see a decline in Illinois, as well as throughout the nation," Ogilvie said.

There is ample evidence of the effectiveness of the Patch approach. Police Captain William Edwards, of the West Palm Beach Police Department, credits the program with a 6% drop in molesting offenses in Palm Beach County, Florida. Similar reductions have been noted by police, school and PTA officials in hundreds of communities, from coast to coast. Further proof is provided in documented reports of 15 children who were approached and refused to be lured because they recalled Patch's rules.

Threat in the Home

Educating children to beware of strangers puts them on the alert, and it can save

their lives. But parents must also be on guard for danger signals within the family's social circle. While there is a natural tendency to reject this possibility, the fact remains that a large majority of children are victimized in their own homes, or other places where they would normally be expected to be safe, and by persons whom they know.¹ A recent study by the U. S. Children's Bureau shows that more than 80% of reported incidents have as the malefactor a relative, neighbor, or friend of the family.²

Why Do They Do It?

Long considered a subject so dreadful that parents could not bear to even think about it, this once-taboo topic has been the subject of recent studies that are serving to dispel many myths about *pedophilia*—the condition from which the molester suffers. What drives a man to seek sexual gratification with a child? And what are the consequences for the victim?

The molester is a mentally sick individual who has not matured psychosexually. One of the peak ages for offenders is in the late teens. Others, in their mid 30's, may seek outlet for their childish sexual impulses as a result of an unsatisfactory marital relationships. In older men, the disturbance often occurs with the onset of senility, though relatively few molesters are old men.

The stereotype of the disgusting old man who harrasses children is fast disappearing with the realization that the molester can be *anyone*—of any age, married or single, from any socio-economic background. He may even have children of his own. Pedophilic tendencies are not uncommon—but often go unsuspected—in teachers, youth leaders, even clergymen and otherwise responsible members of the community.

The most likely victim is a girl between the ages of 8 and 10, who is allowed to wander alone in a public park or street, attends the movies unaccompanied, or who accepts a ride from a stranger or someone she knows only slightly. The second most likely victim is a boy in the 12 to 15 age bracket, in like situations. While in more than 90% of child molestation cases there is no physical injury to the child,³ the molester has been described as "a potential

time bomb of violence, who can explode at any time and anywhere."⁴

The term "child molestation" covers a broad range of sexual intimacies, from non-violent contacts with relatively harmless exhibitionists, touching and fondling, and actual hand-genital contact, to the danger of possible rape, even death. A measure of reassurance is offered in recent findings that a sexual offense committed upon a child apparently has a "relatively minor" effect upon the youngster in later life, and that as few as 5% show serious emotional damage as adults.¹ Whatever the consequences, perhaps the most important lesson we can learn about child molestation is that a great many of these tragedies can be prevented if only parents will recognize that the danger exists and take necessary precautions.

Constructive Action

Dr. John I. Nurnberger, chairman of the Dept. of Psychiatry, Indiana University Medical Center, advises parents to teach children the importance of remembering anything that will aid police in making an apprehension.⁵

Such cooperation is obviously in the best interests of society. As long as the offender remains at large, some other innocent child is likely to suffer the same fate—or worse. But some studies indicate that the legal procedure may harm the child more than the original offense. The requisite medical examination, and repetition of evidence and cross-examination in court serve to keep the incident in the child's mind long after he should have been allowed to forget it.³ When a parent does go to the police, he must be prepared for a pragmatic attitude on their part, and he must make sure he is motivated by a rational desire to protect other children, and to get psychological help for the offender—not a spirit of vengeance.⁷

But guilt in such cases is often hard to prove. The testimony of a child under five is not admissible in court, and older children who are called upon to testify may be subjected to questioning that is often a shattering ordeal.⁸ How the child is treated depends entirely on the sensitivity and tact of the police officers and the judge. Many feel parents would be more willing to co-

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Child Molestation

(Continued from page 732)

operate in the prosecution of sex offenders if greater regard were shown for the rights of the victims.³

In Iowa, the law gives district court judges the option to send sexual psychopaths either to penal institutions or to state hospitals for treatment. Dr. Selig M. Korson, a psychiatrist and superintendent of the State Hospital, Independence, Iowa, takes a pessimistic view. "We have not come up with the answers in such cases," he said. "I don't know of any cure after it has become a way of life with a person. The best procedure is to detect potential offenders early in life, in the early teens." Education and prevention offer the "only real hope," Dr. Korson feels.

Hospitalization or imprisonment protects society only so long as the offender is in custody. Evaluation is often difficult. The molester may be a "model" patient or prisoner, generally well behaved except in the one area in which he cannot control his impulses. But it is hard to predict how he will act on the outside.⁸

In April, a 20-year-old man accused of the 1961 sex slaying of a seven-year-old Elmhurst girl was freed after spending more than seven years in state mental hospitals—first in the Illinois Security Hospital, Chest-er, and in the Manteno State Hospital since then. Ruled innocent of murder at the time of the crime, the youth, who was then a seventh grade pupil, has now been judged sane on the basis of testimony by two defense psychiatrists. One can only hope that this is a case where early detection and treatment have, indeed, effected a cure.

Perhaps the best solution lies in a combination of security and treatment, as exemplified by Wisconsin, which provides long-term care in a special security hospital where sexual deviates are effectively separated from society and receive psychiatric care until "such time as it is felt they can be released."⁵ In New Jersey, the State Institutions Department is currently seeking an increase in its annual budget to build a separate unit to house 160 sex offenders at the Rahway Prison. Iowa, Pennsylvania and Hawaii are among other states to seek stronger laws for the control and prevention of sex crimes.

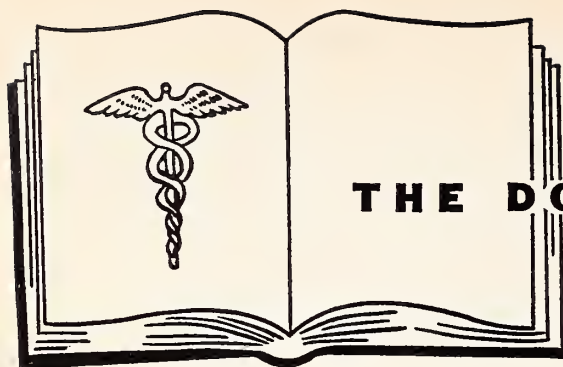
The Physician's Role

While there is no single answer to this complex social problem, the physician may effect remedial action on several levels—as a citizen, as a parent, and as a doctor. Perhaps his most sensitive role is that of the healer, who may be called upon to treat a molested child and to counsel the concerned parents. Generally, even a serious incident in childhood will not interfere with a youngster's ability to achieve an emotionally healthy attitude toward sex in later life.¹ But our society tends to be irrational about sex. Increasing evidence indicates that often children are more disturbed by the highly-charged emotional reaction of parents than they are by the actual encounter. At a time when the greatest possible self-control is needed, parents may be subject to exaggerated feelings of guilt, rage and a demoralizing sense of their own inadequacy to protect their child's "sexual innocence."

While understandable, the parent's inflamed feelings can lead to unfortunate consequences for society, the offender, and the child himself. In discussing what may have been a trivial incident for the child, a calm, nonalarming approach should be used. The child will want to know why this has happened to him. Explanations should be given on the child's own level, in terms he can understand, and in a way that will not undermine his sense of trust in the adult world. Mention of sexual perversions or anything else that will instill a fear of adults in the child's mind should be avoided. The child knows that adults sometimes behave badly—drinking, smoking, driving recklessly and fighting among themselves. He must be made to understand that the incident has nothing to do with him personally, and that such behavior stems from just another human defect that is fortunately rare in the people he is likely to meet.⁷

Certainly the physician can do much to prevent these tragedies simply by alerting parents to the danger, and urging them to take ordinary precautions. At the community level he may also help by encouraging the PTA, schools, police and civic groups to undertake preventive programs, such as Patch the Pony, Block Parents and similar

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THE DOCTOR'S LIBRARY

CLINICAL ASPECTS OF OPERABLE HEART DISEASE. By Donald Kahn, Ruth Strang, William Wilson, Appleton-Century Crafts, Copyright 1968.

This book is an exceedingly good, comprehensive review of the natural history and treatment of the various operable cardiac conditions, both congenital and acquired. The book has 360 pages, 24 chapters, covering many of the aspects of cardiac surgery, including a short review of electrocardiography, cardiac catheterization, pre- and postoperative care; as well as a chapter on cardiac transplantation.

The book is clearly written, well organized, in that the pathologic physiology of each lesion is discussed in the order of diagnosis, natural history and treatment, and the surgical technique used to treat the lesion. The surgical technique is exceedingly abbreviated, which makes the book worthwhile for all house staff and nurses as well. This book can be utilized by the nurses, medical students, interns and residents who are interested in a more complete treatise of cardiac surgery. The authors have accomplished in a concise, clear manner what they portrayed in the title: namely *the clinical aspects* of operable heart disease, with the emphasis on the clinical aspects.

The authors probably were plagued with just how much to include in a book of this type. If there is any criticism of the book, I would think it would be that perhaps a chapter on cardiorespiratory physiology should have been included with cardiac catheterization. However, this is a little distant from the clinical aspects of operable lesions, but in view of the fact that a chapter on cardiac catheterization, electrocardiography and the pre- and postoperative care were included, it would appear to be more complete if cardiorespiratory physiology

was dealt with to bring the reader up to date with the role of the respiratory system in cardiac disease.

The book is attractively bound, with its title clearly portrayed so that the back of the book will stand out in a library as a reference book. Its print is large, the drawings are clear, and the book is exceptionally light weight, and an asset to any hospital library.

Arthur DeBoer, M.D.

WOLFF'S ANATOMY OF THE EYE AND ORBIT.

By R. J. Last, Sixth Edition, W. B. Saunders Company, Philadelphia, 1968.

Sometime after the publication of the fourth edition of this text, Eugene Wolff died and the last two editions have been revised by R. J. Last. The fifth edition appeared in 1961, and a new edition within seven years speaks for the continuing vitality and usefulness of this book. Although there are larger and more comprehensive textbooks of anatomy of the eye, for example Volume II of Duke-Elder's *System of Ophthalmology*, there does seem to be a place for a book that can be held in one hand. For example, a very popular book earlier in the century (and still an excellent reference for dissection of the orbit) was Whitnall's *Anatomy of the Human Orbit*. It has not been revised or reissued since 1932, which may be related to the appearance of the first edition of *Wolff's Anatomy* in 1933, since the latter included the globe as well as the orbit.

This new sixth edition is some 30 pages longer than the previous one and most of this increase is due to the inclusion of about 30 electron micrographs in the chapter on the eyeball. Curiously, these are clearer and sharper than the photomicro-

graphs which are generally muddy. The numerous drawings, on the other hand, are first class.

All the anatomy that an ophthalmologist in training or in practice need know can be found in this book and at its price it is, to use the term of consumer research organizations, a Good Buy.

David Shoch, M.D.

PEDIATRIC THERAPY. Third Edition, Revised and Enlarged, Edited by Harry C. Shirkey, B.S. (Pharm.), M.D., F.A.A.P. 1,294 pp., illustrated; St. Louis, The C. V. Mosby Co., 1968, \$25.00.

In this third edition of *Pediatric Therapy*, the high standard of the previous volumes has been more than adequately maintained. Also, the impressive array of 72 contributors attests to the continued confidence in and qualifications of the editor.

Dr. Shirkey has enlarged the scope of his book by the addition of seven new chapters and has made major revisions in most of the other sections. Three of the new chapters dealing with the neonate are particularly pertinent: Chapter 18, "Drugs Excreted into Breast Milk;" Chapter 38, "Newborn Special Care;" and Chapter 40, "Systemic Antimicrobial Therapy." The "Table of Drugs," already ample, has been expanded and the repetitious listing of

these preparations and doses in other chapters is avoided. Also, the section on "Poisoning and Its Treatment" is again a ready source of valuable and often needed information for the common as well as the more exotic childhood intoxications.

The "baby blue" and "pink" coloring of these two respective chapters adds a bit of pediatric flavor and, by the way, appreciably decreases searching time for important and frequently used information.

The first four sections dealing with "Drug Therapy," "Drug Reactions," "General Therapy," and "Treatment of Symptoms," alone are worth investment in the text. These chapters are sprinkled with fine illustrations, graphs and charts, and many "pearls" of pediatric care. Moreover, they stress background and reasons for therapy, thus avoiding the stereotype "cook book" approach found in so many other volumes dealing with this subject.

The index is good and the bibliography limited, but there is usually a good reference to a recent definitive article in most sections. The book is well produced, the pages, type and format all lend themselves to easy reading, and I found few areas that are open to the usual reviewers "nit picking."

This book is a must for the busy pediatrician in his office and at the bedside, and for the house officer in the emergency room or on the wards.

James W. Nicklas, M.D.

Film Reviews

A new film catalog entitled, "Selected Films: Heart Disease, Cancer and Stroke," has been compiled by The National Medical Audiovisual Center. It serves as a quick and ready reference to selected films on heart disease, cancer and stroke for professional and nonprofessional audiences. Titles relating to heart disease and cancer represent only a small proportion of films available on these diseases. However, the scarcity of films on stroke has been re-emphasized during preparation of the list. The catalog may be secured by writing to: U. S. Department of HEW, Public Health Service, National Library of Medicine, National Audiovisual Center, Atlanta, Georgia 30333.

Five discussions of the current concepts in the management of specific cancers are now available on 16 mm. films for viewing by physicians. The discussions were taken from the 1967 and 1968 meetings of the American Radium Society and produced and distributed as a joint effort of the ARS and ACR Committees on Audio-Visual Media. Single prints of the longer 1967 films are available for loan from the AMA film library, 525 North Dearborn Street, Chicago, Ill.; while the 1968 films can be borrowed from the AMA and can be purchased from the American College of Radiology, 20 North Wacker Drive, Chicago, Ill., for \$55.00 per print.

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Study Students for Coronary History

Smoking, excess weight, and high blood pressure among college students was associated with a life foreshortened by fatal coronary heart disease, National Heart Institute scientists reported at the 41st Scientific Session of the American Heart Association in Bal Harbour, Florida.

Reviewing the college health records of 50,000 former Harvard and University of Pennsylvania students, the scientists evaluated the three factors for their subsequent cumulative effects on death in later years from coronary heart disease, specifically in the 24-44 and 45-64 age brackets.

Dr. Ralph S. Paffenbarger, Jr. and Alvin L. Wing reported that, in both age groups,

the combination of any 2 or all 3 characteristics more than doubled the risk of fatal coronary heart disease. Smoking 10 or more cigarettes per day increased the risk of a fatal attack by 62 percent in the absence of high blood pressure and overweight. High blood pressure alone (systolic blood pressure of 130 mm of mercury or more) increased the risk by 58 percent, and overweight alone increased the risk by 33 percent in the NHI study.

The study adds further evidence to the statistical relationship of the three principal characteristics of the coronary profile and development of premature heart disease.

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(Continued from page 716)

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R

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Emergency Physicians Form National Organization

Increasing patient loads in Emergency Departments across the country and the demand for a new type of physician (skilled in emergencies) has brought about the formation of the recently organized American College of Emergency Physicians.

Originally founded by a nucleus of Michigan physicians, the group's main purpose is to improve emergency services rendered to the patient.

Other aims of the newly founded college include: encouraging, implementing and continuing education of emergency care facilities and personnel, and advancing the ethical standards of the private practice of Emergency Medicine and Surgery.

Representatives from 19 states recently met in Chicago to formulate a constitution and bylaws and to plan the future of the organization.

Attending physicians noted that the first and most important order of business is to attract those physicians who are working, full-time or part-time, in Emergency Departments across the country.

For further information physicians are urged to write: Exec. Secretary, American College of Emergency Physicians, 120 West Saginaw St., East Lansing, Mich. 48823 or Illinois' Representative: E. W. Donelan, M.D., 2425 Glenwood, Springfield, 62704.

Meeting Memos

June 20-21—American College of Anesthesiology

Oral Examination
Chicago

July 11-17—Woman's Auxiliary to the American Medical Association

Annual Meeting
Waldorf-Astoria Hotel, New York City, New York

July 12—Disease Detection Information Bureau

Diabetes Detection
New York Hilton, New York, New York
"Practical Planning for Community Screening Programs"

July 12—American Association for the Study of Headache

Annual Meeting
New York Hilton, New York, New York

July 12-13—Society for Vascular Surgery

New York City, New York

July 12-13—Society for Investigative Dermatology

Annual Meeting
New York Hilton, New York, New York

July 13—American College of Legal Medicine

Professional-Clinical Meeting
Warwick Hotel, New York City, N.Y.
"The Physician And The Law"

July 13-17—American Medical Association

118th Annual Convention
Americana Hotel
New York City, New York

July 18-19—American Cancer Society & the Colorado Medical Society

23rd Annual Rocky Mountain Cancer Conference
Brown Palace Hotel, Denver, Colorado

Safety Caps

Significant progress toward developing standard performance tests for safety closures used on medicine bottles and other types of containers was announced during the recent meeting of the American Academy of Pediatrics in Chicago.

Results of a study which tested 72 adults and 72 children who used snapoff, Palm-N-Turn, and press-and-turn closures, as well as standard screw top closure, indicated that the Palm-N-Turn and press-and-turn closures were so effective, that practically none of the children tested could remove these closures even though the method for opening them was demonstrated.

Significantly only 22 of 36 healthy adults could open these closures without demonstrations.

Results of the study were reviewed at the AAP meeting by a national committee to develop standards for safety closures for aspirin and other medicine. The study

was financed by the Proprietary Association, and conducted by the Biological Science Laboratories of Foster D. Snell, Inc.

Edward Press, M.D., Oregon State Health Officer and chairman of the committee, emphasized that results of this study, and two other studies, represent a significant step toward developing safer and more reliable closures for medicine bottles and other containers which can constitute safety hazards for children. He also pointed out that an expansion of the study to check on its reproducibility and uniformity would be required before any formal recommendations can be made.

The committee to develop standards for safety closures has been appointed by the Food and Drug Administration of the U.S. Department of Health, Education, and Welfare to enable industry and regulatory agencies to jointly develop recommendations for standards for safety closures.

COOK COUNTY
Graduate School of Medicine
CONTINUING EDUCATION COURSES
STARTING DATES—1969

SPECIALTY REVIEW COURSE FOR FAMILY PRACTICE, July 21
 SPECIALTY REVIEW COURSE IN SURGERY, Part I, August 11
 SPECIALTY REVIEW COURSE IN THORACIC SURGERY, Sept. 15
 SPECIALTY REVIEW COURSE IN MEDICINE, Part I, Sept. 15 & 29
 PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
 MANAGEMENT OF BURNS, Two Days, June 6 & 7
 BASIC PRINCIPLES IN GENERAL SURGERY, Two Weeks, June 16
 PROCTOSCOPY & VARICOSE VEINS, One Week, June 23, Sept. 9
 ADVANCED PERIPHERAL VASCULAR SURGERY, One Week, July 7
 ADVANCED HAND SURGERY, Three Days, September 9
 SURGERY OF HEAD & NECK, One Week, September 15
 SURGERY OF STOMACH & DUODENUM, One Week, Sept. 15
 VAGINAL APPROACH TO PELVIC SURGERY, One Week, June 9, Sept. 15
 ADVANCES IN GYNECOLOGY & OBSTETRICS, One Week, Sept. 29
 PEDIATRIC SURGERY, One Week, September 29
 ADVANCED HEMATOLOGY, One Week, June 16
 RADIOISOTOPES, One or Two Weeks, Request Dates

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THE VIEW BOX

(Continued from page 700)

Diagnosis: Large bowel obstruction with secondary small bowel obstruction as a result of a perforated diverticulitis.

An examination of Fig. 1 reveals the marked distention of small bowel which is recognized by the presence of valvulae conniventes which extend throughout the width of the bowel lumen. The distended bowel ascends in a vertical fashion from the right lower quadrant to the left upper quadrant. However, further observation reveals an obviously dilated splenic flexure in the left upper quadrant when one identifies the obvious haustral markings. Thus, we have to deal with not only a small bowel obstruction but a definite large bowel obstruction as well. Further identification is possible as to the etiology by the radiolucent linear streak seen immediately above and extending down past the iliac crest on the left side. This constitutes an intramural dissection of air. An emergency barium enema revealed acute diverticulitis with a complete obstruction of the large bowel. Again the intramural extension of air is seen along the medial border of the descending colon. The failure of distensibility of the involved segment of colon is a result of a soft tissue abscess which not only involves the sigmoid colon but is secondarily causing a small bowel obstruction as a result of adhesions to the phlegmon.

The diagnosis of gross perforation and formation of a paracolic abscess is readily made when the abscess communicates freely with the gut and barium enters the abscessed cavity. The extravasated barium does not usually outline a total extension of the abscess cavity or inflammatory mass. The complications of diverticular rupture should be kept in mind whenever inflammatory masses develop in these regions in elderly patients in the presence of diverticular of the sigmoid, even if no barium outlines an abscess or a fistula. Thus, a left sided pelvic abscess in an elderly male is most commonly caused by a ruptured sigmoid diverticulum. ◀

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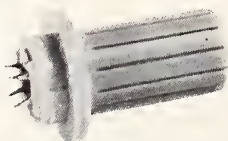
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472-9

Oldsters Revolt

GERIATRICS Gap, Ga.: Police were called today to help restore order at the Bide-A-Wee Rest Home, scene of a weeklong senior citizens' revolt.

Three militant octogenarians were arrested after a scuffle that took place in the main parlor.

They were identified as leaders of an activist group that seized control of the parlor three days ago and locked Mrs. Birdie McMush, assistant dietitian, in the pantry.

Quincy Tiredblood, 88-year-old spokesman for the rebellious faction, told reporters the demonstration was staged to enforce demands that old folks be given a greater role in the management of the rest home. "We've got a bunch of young whipper snappers running things around here," he said, waving his cane indignantly. He said the old folks were demanding that at least three senior citizens be added to the rest home staff. "We don't trust anybody under 65," said Tiredblood, who had a "Senility Power" button pinned to his shawl.

The revolt began last week when a small group of hardcore super annuates held a dodder-in at which some burned their Social Security cards. Although peaceable in its early phases, the protest movement took a violent turn when someone hit Clem Snaffle, rest home superintendent, with a bottle of Geritol.

Snaffle blamed the trouble on misunderstandings caused by difficulties in communicating with the militants. "Some of them turned off their hearing aids," he said.

But Tiredblood warned that the demonstration will continue until after all of their demands have been met, "What's the sense of living a long time if some kid who's only 45 or 50 years old can tell you what to do?" he said, his dentures clacking. "Most of the kids nowadays are finks."

Author Unknown

The University of Illinois Medical Center Campus, located in the 363-acre medical district on Chicago's near-west side, has 2,680 students in its Colleges of Dentistry, Medicine, Pharmacy and Nursing and Graduate College.

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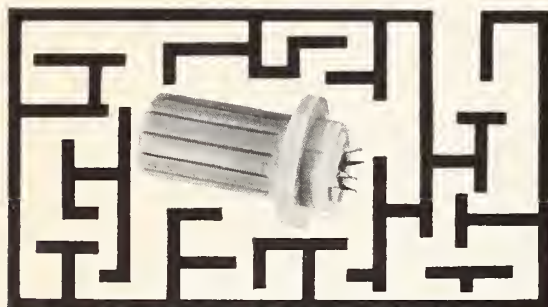
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Child Molestation

(Continued from page 735)

efforts to safeguard children. Anyone interested in staging a Patch the Pony program in his community may obtain a free, descriptive brochure by writing: Society for Visual Education, Inc., 1345 Diversey Parkway, Chicago 60614. This brochure will be supplied in any desired quantity to physicians who wish to place them in their waiting rooms.

While widespread application of preventive measure will greatly reduce the threat of molestation, it is incumbent upon society to study the factors which impel a person to prey upon children, and to seek more effective means of treatment and control. Clearly, much remains to be done. ◀

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Award Grant For Protein Study

A grant of \$232,356 has been awarded to the University of Chicago by The John A. Hartford Foundation, Inc., to study the regulation of protein synthesis in cells.

The funds, under the direction of Dr. Ira G. Wool, professor of physiology and biochemistry, will be used over a three-year period to continue research on a series of fundamental problems including the mechanisms by which some hormones influence growth.

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